# Massage Client Intake Form

Welcome! We would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let us know.

**Personal Client Information** Date _____

Name (First, Middle Initial, Last) _____ o Male o Female

Home Phone _____Work Phone _____ Cell Phone _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Email _____

Emergency Contact _____ Relation _____Phone _____

How did you hear about us or Referred by _____ Phone _____

Would you like to be notified via email or mail of specials and seasonal discounts? o Yes o No

**General and Medical Information**

**The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.**

| | | |
|---|---|---|
| Have you ever had a professional massage before? | o Yes o No | If yes, how often? |
| Do you have any difficulty lying on your front, back, or side? | o Yes o No | If yes, please explain: |
| Do you have any allergies to oils, lotions, or ointments? | o Yes o No | If yes, please explain: |
| Do you have sensitive skin? | o Yes o No | If yes, please explain: |
| Are you wearing: | o contact lenses o dentures o a hearing aid | |
| Do you perform any repetitive movement in your work, sports, or hobbies? | o Yes o No | If yes, please explain: |
| Do you have any particular goals in mind for this massage session? | o Yes o No | If yes, please explain: |
| Are you pregnant? | o Yes o No | |
| Do you have or have you had Cancer | o Yes o No | |
| Have you had any lymph nodes removed? | o Yes o No | |
| Are you currently under medical supervision? | o Yes o No | If yes, please explain: |
| Are you currently taking any medications? | o Yes o No | If yes, please list: |

Please check off and circle any of the following conditions or symptoms which apply to you:

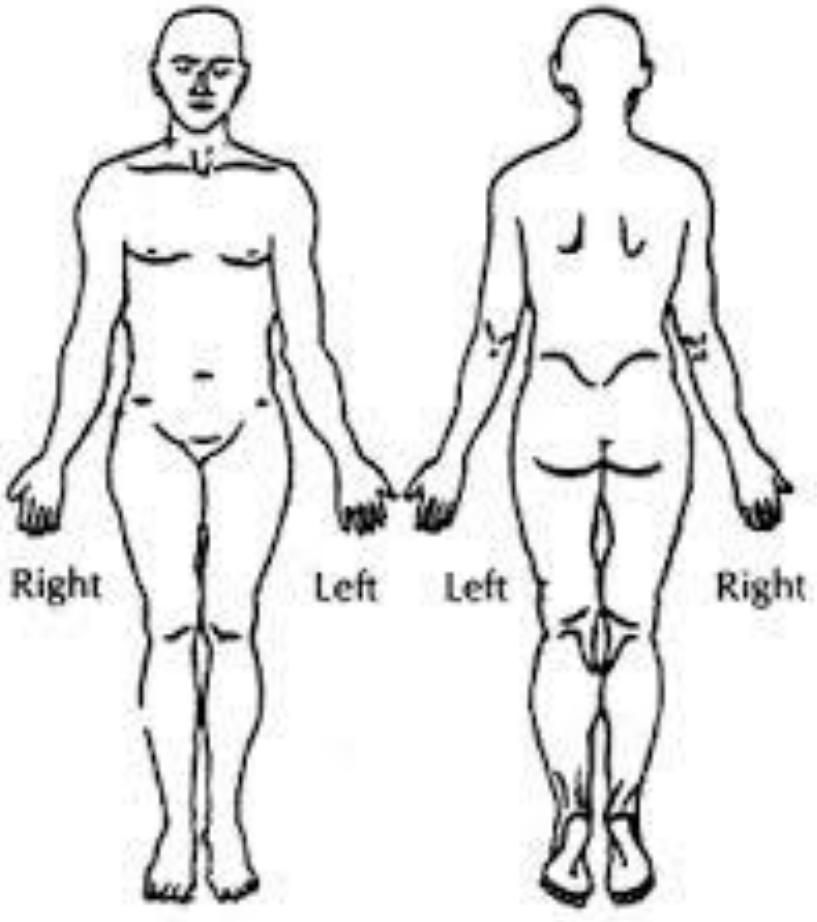
- o Blood Pressure: low/high
- o Headaches: tension/stress
- o Back Pain: lower/mid/upper
- o Allergies (scents, nuts, etc)
- o Skin Conditions (rashes, acne)
- o Numbness: arms/hands/legs/feet
- o Easy Bruising
- o Varicose Veins
- o Sinus Problems
- o Tingling within past 3 months
- o Fatigue within past 3 months
- o Injury within past 5 years
- o Heart Problems
- o History of Strokes
- o Rheumatoid Arthritis
- o Cancer
- o Asthma
- o Diabetes
- o Blood Clots
- o Osteoporosis
- o Pain within past 3 months
- o Swelling within past 3 months
- o Surgery within past 5 years

Is there anything else about your health history that you believe would be useful for us to know?

_____

_____

_____




Please indicate the following on the picture(s):

X for please concentrate massage

P for pain

I for injury

S for swelling

N for numbness

T for tingling

**Lifestyle & Occupation**

Please circle the answer closest to how you presently feel (1 = poor, 5 = excellent):

| | | | | | |
|---|---|---|---|---|---|
| Quality of sleep | 1 | 2 | 3 | 4 | 5 |
| Energy level | 1 | 2 | 3 | 4 | 5 |
| Exercise habits | 1 | 2 | 3 | 4 | 5 |
| Fluid intake | 1 | 2 | 3 | 4 | 5 |

Occupation: _____

How many hours per week on average? _____

How do you spend most of your work day?

❑ Sitting ❑ Sitting w/ mostly computer work ❑ Standing

❑ Light manual labor ❑ Manual labor ❑ Hard Manual Labor

Current Stress Level:

❑ Constant ❑ Moderate ❑ Mild ❑ None

What kind of pressure do you prefer? O Light O Medium O Firm

**Draping will be used during the session - only the area being worked on will be uncovered.**

**Cancellation Policy - $25 same day cancellation fee**

# Pregnancy Health Intake Form

Name of obstetric care provider _____

Name of clinic _____

Address _____

Phone number _____ Fax Number _____

**Pregnancy Information**

I have had _____ previous pregnancies and _____ previous births.
I'm carrying ❑ one baby ❑ twins or more

Estimated Due Date: _____ Week of pregnancy: _____
I am having a ❑ boy ❑ girl ❑ surprise ~

Baby's Name: _____
Have you ever experienced any of the following?
❑ Miscarriage ❑ Ectopic pregnancy ❑ Stillbirth

**Previous Births** Most Recent <--- to ---> Least Recent

| | | | | | |
|---|---|---|---|---|---|
| Birth date: | _____ | _____ | _____ | _____ | _____ |
| Cesarean birth: | ❑ | ❑ | ❑ | ❑ | ❑ |
| < 38wks premature: | ❑ | ❑ | ❑ | ❑ | ❑ |
| Birth was induced: | ❑ | ❑ | ❑ | ❑ | ❑ |

Child's name: _____ _____ _____ _____ _____

**Pregnancy Related Conditions**
Please indicate any **pregnancy related** conditions you have experienced either in this current pregnancy (check "C" box) or in any past pregnancies (check "P" box):

| C | P | | C | P | |
|---|---|---|---|---|---|
| ❑ | ❑ | Preterm Labor | ❑ | ❑ | Headaches/Migraines |
| ❑ | ❑ | Pre-Eclampsia | ❑ | ❑ | Sinus Concerns |
| ❑ | ❑ | Gestational Diabetes | ❑ | ❑ | Swelling Feet or Hands (Edema) |
| ❑ | ❑ | Am over 36 years old | ❑ | ❑ | Varicose Veins |
| ❑ | ❑ | Hypertension, High BP | ❑ | ❑ | Heartburn/indigestion |
| ❑ | ❑ | Placental Dysfunction | ❑ | ❑ | Hemorrhoids |
| ❑ | ❑ | Bladder or kidney infection | ❑ | ❑ | Dizziness/Fainting |
| ❑ | ❑ | Leg Cramps or Restless Leg | ❑ | ❑ | Anemia |
| ❑ | ❑ | Pain in Pubic Bone | ❑ | ❑ | Constipation |
| ❑ | ❑ | Threatened miscarriage | ❑ | ❑ | Morning Sickness, vomiting or nausea |
| ❑ | ❑ | Sciatica | ❑ | ❑ | Restricted Breathing |
| ❑ | ❑ | Carpal Tunnel Pain | | | |

List any physical disabilities, ailments, allergies, etc. that are not mentioned above:

_____

_____

# Cancer Health Intake Form

1. What kind of activities are you able to participate in?_____
   _____
   _____
2. When were you first diagnosed with cancer?_____
3. What type of cancer?_____
4. Is cancer currently active? Yes No
5. Where was/is it located?_____
   _____
6. Are you being treated now? Yes No If no, what was the date of your last treatment? _____
7. What treatments have you undergone, when? Please list dates and types of surgery and other treatments.
   _____
   _____
8. Current cancer medications not described above. _____
   _____
9. Did your treatment include any removal or radiation of lymph nodes? Yes No If yes, please describe where.
   _____
10. Did your treatment include radiation therapy? Yes No If yes, please describe where.
    _____
    _____
11. Do you have any site/pressure/position restrictions due to
    - ☐ Incisions, open wounds, drains or dressings ☐ skin sensitivity, rash or skin condition
    - ☐ IV, port, ostomy, catheter, or other device ☐ history or risk of lymphedema
    - ☐ tumor site ☐ radiation site ☐ neuropathy ☐ anticoagulants
    - ☐ Bone or spine metastasis ☐ fracture history ☐ area of infection or fever
    - ☐ History/risk of blood clot ☐ low platelet count ☐ fragile/sensitive skin
    - ☐ Steriod med ☐ fragile veins ☐ area of pain or burning
    - ☐ Fatigue ☐ recent surgery ☐ difficulty breathing ☐ discomfort
    - ☐ Swelling or risk of swelling (any area need elevating) ☐ other _____
      _____
12. Has cancer or treatment affected any of the following functions in your body?
    - ☐ Lungs ☐ Liver ☐ Nervous system ☐ Heart ☐ Lung
    - ☐ Kidney ☐ Blood counts ☐ Energy Level ☐ Digestive ☐ Respiratory

    Circle any that you are currently experiencing and describe

    _____
    _____
13. Any sites of numbness or reduced sensation anywhere in your body? Yes No If yes, please describe
    _____
14. Any areas of inflammation? Yes No If yes, please describe
    _____
    _____

# Massage Therapy Inform Consent

I, _____ (print name), understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension.

I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of.

I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability to the employees, and the therapist's part should I fail to do so.

**Please read and initial all of the following statements:**

_____ If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold the employees or my therapist responsible for any pain or discomfort I experience during or after the session.

_____ I affirm that I have notified my therapist of all known medical conditions and injuries.

_____ I understand that **massage is entirely therapeutic and non-sexual in nature** and the session will terminate immediately if sexual in nature.

_____ By signing this release, I hereby waive and release the employees or my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

Client's Name _____

Client's Signature _____ Date _____

**Parental consent to treatment of a Minor:** By my signature below, I hereby authorize my therapist to administer massage or bodywork therapy techniques to my child or dependent as the therapist deems necessary.

Signature of Parent/Guardian _____ Date _____

Therapist's Name _____

Therapist's Signature _____ Date _____