Client Intake Form- Therapeutic Massage

Name________________________________Phone___________________ DOB___________

Address____

City/State/Zip__________________________________ Referred by__________________________

Email_____________________________________ Occupation___________________________

Emergency Contact_________________________________ Phone______________________

Please answer the questions to the best of your knowledge.

1. Have you had a professional massage before? Yes No

   If yes, how often do you receive massage therapy? ______________________________

2. Do you have any difficulty lying on your front, back, or side? Yes No

   If yes, please explain____

3. Do you have any allergies to oils, lotions, ointments or scents? Yes No

   If yes, please explain____

4. Do you have sensitive skin or bruise easily? Yes No

   If yes, please describe____

5. Are you wearing contact lenses ( ) dentures ( ) hearing aid ( ) ?
6. Do you sit for long hours at workstation, computer or driving? Yes No

   If yes, please describe____

7. Do you perform any repetitive movement in work, sport or hobby? Yes No

   If yes, please describe____

8. Do you experience stress? Yes No
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

   If yes, please identify____

10. What are your massage goals? ____

11. Are you currently under medical supervision? Yes No

    If yes, please explain____

12. Are you currently taking any medications? Yes No

    If yes, please list____

13. Please circle any condition listed below that applies to you:

contagious skin condition	phlebitis
open sores or wounds	deep vein thrombosis/blood clots
easy bruising	rheumatoid arthritis/ osteoarthritis/tendonitis
recent accident or injury	osteoporosis
recent fracture	epilepsy/ seizures
recent surgery	headaches/ migraines
artificial joint	cancer
sprains/ strains	diabetes
current fever	decreased sensation
swollen glands	back/neck problems
allergies/sensitivity	fibromyalgia
heart condition	tmjd
high or low blood pressure	carpal tunnel syndrome
circulatory disorder	tennis elbow
varicose veins	cold/flu like symptoms
atherosclerosis	pregnancy if yes, how many months?

Please explain any condition circled?____

____

____

14. Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you? _________________

____

I___________________________ understand and voluntarily accept any risks of which I have been advised about and associated with my massage, of from any use of the company's facilities, and hereby release the following therapists and entities: Courtney Dortch, LMT- From Me To You Massage Therapy, from all liability for any injury, including, without limitation, personal, bodily or mental injury, from all liability arising from any such injury or damage resulting from my failure to disclose any pre-existing condition, determine that it is unsafe for me to proceed with or continue a therapeutic session due to health related concerns. In this event I must provide the therapist with a physician's medical release prior to continuing treatment. **12-hour advance notice is required** when cancelling an appointment. If you are unable to give us 24 hour notice you will be charged/billed **full amount** of your appointment. This amount must be paid prior to your next scheduled appointment. **Treatment of minor:** My signature below authorizes for the therapist to administer massage, bodywork, or somatic therapy treatment to my child or dependent as they deem necessary. I undersigned acknowledges that he/she has read the agreement.

Client Signature____________________________________Date______________________

Therapist Signature__________________________________ Date_____________________