CLIENT INTAKE FORM

Captivating massage therapy

PERSONAL INFO **DATE: _____**

_____
name date of birth

_____
street address

_____
city state zip

_____
cell phone

_____
email

_____
occupation

_____
employer

_____
marital status if married, spouse's name

_____
referred by

_____
emergency contact (relationship, name & phone)

_____
physician's name physician's phone
(if being treated for a specific illness or injury)

Current Health

Have you had a professional massage? ☐ Yes ☐ No

Reason for visit: _____
_____
_____

Preferred pressure: ☐Light ☐ Medium ☐ Deep

Do you participate in any sports/activities? ☐ Yes ☐ No

If yes, what kind? _____

Do you perform any repetitive movement in your work, sports or hobby? ☐ Yes ☐ No If yes, please describe:
_____

Do you sit for long hours at a workstation, computer or driving? ☐ Yes ☐ No If yes, please describe: _____
_____

Do you experience stress in your work, family, or other aspects of life? ☐ Yes ☐ No If yes, please describe:
_____
_____

Are you experiencing tension, stiffness, discomfort or pain? ☐ Yes ☐ No If yes, please describe: _____
_____

Have you recently had an injury, surgery, or area of inflammation? If yes, please describe: _____
_____
_____

Do you have sensitive skin? ☐ Yes ☐ No

Do you have any allergies to oils, lotions or ointments? ☐ Yes ☐ No If yes, please explain: _____

List any known allergies: _____

List any medications you are currently taking: _____
_____
_____

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Health History

Musculoskeletal
__ Bone or Joint Disease
__ Tendonitis/Bursitis
__ Arthritis/Gout
__ Jaw Pain (TMJ)
__ Lupus
__ Spinal Cord Problems
__ Migraines/Headaches
__ Osteoporosis

Circulatory
__ Heart Condition
__ Phlebitis/Varicose Veins
__ Blood Clots
__ High/Low Blood Pressure
__ Lymphedema
__ Thrombosis/Embolism

Skin
__ Rashes
__ Cosmetic Surgery
__ Athlete's Foot
__ Herpes/Cold Sores

Psychological
__ Anxiety/Stress Syndrome
__ Depression

Other
__Cancer/Tumors
__ Diabetes
__ Drug/Alcohol/Tobacco Use
__ Contact Lenses
__ Dentures
__ Hearing Aids

Respiratory
__ Breathing Difficulty/Asthma
__ Emphysema
__ Sinus Problems

Nervous System
__ Shingles
__ Numbness/Tingling
__ Pinched Nerve
__ Chronic Pain
__ Paralysis
__ Multiple Sclerosis
__ Parkinson's Disease

Reproductive
__ Pregnant, stage: _____
__ Ovarian/Menstrual Problems
__ Prostate Issues

Digestive
__ Irritable Bowel Syndrome
__ Bladder/Kidney Ailment
__ Colitis
__ Crohn's Disease

Any other medical Condition(s) not listed:
_____
_____
_____
_____

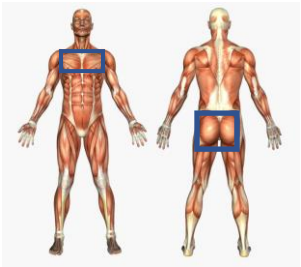
Client Agreement

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. **Initial _____**

WASHINGTON STATE REQUIRED QUESTIONS:

I (give consent) / (prefer not) to receive massage on my hips/gluteal muscles. Please circle preference and initial:_____

I (give consent) / (prefer not) to receive massage on my pectoral muscles. For males only, I (give consent) / (prefer not) to have my chest uncovered during my treatment. Please circle preference and initial:_____



Consent to treat:

_____
Signature / signature of legal guardian