Therapeutic Massage – Client Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City, State, Zip _____

Date of Birth _____ Email _____

Emergency Contact _____ Phone _____ Occupation _____

Physician _____ Phone _____ Do you text? Y or N #_____

Massage Information

How did you hear about us? _____

Have you ever had a professional massage before? ☐yes ☐no

If yes, how often to you receive massage therapy? _____

If yes, do you have a style or pressure preference? ☐yes ☐no

Specify : ☐ light pressure ☐ medium pressure ☐ deep pressure

☐ trigger point therapy ☐ energywork

☐ Other _____

What Type of massage are you seeking today?

☐ Relaxation ☐ Deep Tissue/Therapeutic ☐ Pregnancy

☐ Senior ☐ Integrated Bodywork (*functional*)

☐ Other _____

Are you sensitive to fragrances or perfumes? ☐ yes ☐ no

Do you have sensitive skin? ☐ yes ☐ no

Do you wear contact lenses? ☐ yes ☐ no

Do you exercise regularly? ☐ yes ☐ no

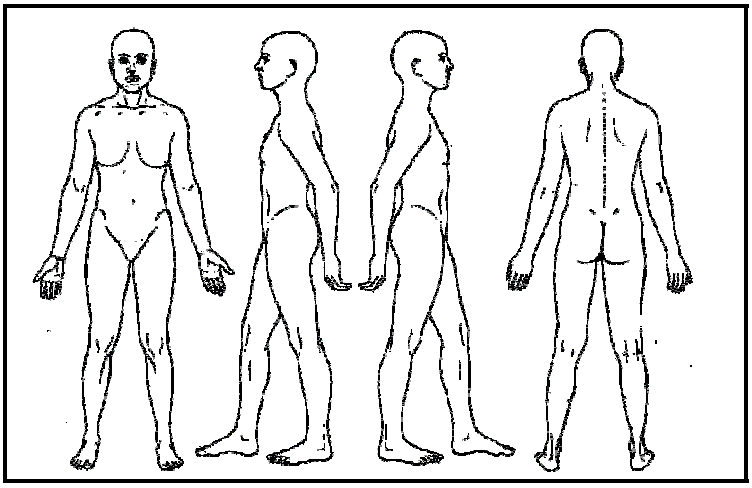
If so, what type(s)? _____

What are your common areas of pain or tension?

_____

_____

Circle any specific areas you would like the massage therapist to concentrate on during the session:



Medical History

Do you suffer from chronic or persistent pain/discomfort?

_____

If so, for how long? _____

Do you know what caused it or when then symptoms seem to get worse or better? _____

_____

Do you see a chiropractor? ☐ yes ☐ no

If so, how often? _____

Are you currently under medical care? ☐ yes ☐ no

Are you currently taking any prescription medication? If so, for what? _____

_____

_____

Please indicate any conditions that you have had or currently have:

☐ headaches, migraines	☐ varicose veins
☐ allergies, sensitivity	☐ pregnancy
☐ arthritis, tendonitis	☐ blood clots
☐ cancer, tumors	☐ neck / back injuries
☐ TMJ problems	☐ diabetes
☐ abnormal skin condition	☐ paralysis
☐ heart/circulation problems	☐ fibromyalgia
☐ joint replacement / surgery	☐ numbness
☐ high / low blood pressure	☐ sprains, strains
☐ major accident	☐ recent injuries

☐ lack of or reduced feeling / sensation _____

Explain any conditions that you have marked above:

_____

_____

_____

Clear Form

Informed Consent and Massage Policies

I understand that the massage I will be receiving here is for the purpose of stress reduction, relief from muscular tension or spasm. I understand that the massage therapist does not diagnose illness, disease, or any further physical or mental disorders. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations. I understand that massage is not a substitute for medical treatment or diagnoses and that it is recommended that I see a physician for any physical ailments that I may have.

I acknowledge that the information I have provided on this form is correct and current to the best of my knowledge. I understand that it is my responsibility to inform the massage therapist of any changes to this information. I understand that if I experience any unusual discomfort and/or pain during my massage sessions it is my responsibility to inform the massage therapist so that they can adjust the pressure or technique being used.

Privacy Policy

All written records and massage sessions are kept strictly confidential and will not be shared with any outside establishment, individuals, organizations, or medical facilities without explicit written consent from the client (you) or the client's legal guardian. Unless legally required by local, state, or federal subpoena, summons, or other court order.

No-Show and Late Cancellation Policy

I understand that I will be charged a No-Show and/or Late Cancellation fee of 25% of my scheduled service if I fail to give at least 24 hours notice prior to cancelling or not showing up for my scheduled appointment for the first occurrence.

I understand that I will be charged a No-Show and/or Late Cancellation fee of 50% of my scheduled service if I fail to give at least 24 hours notice prior to cancelling or not showing up for my appointment for the second (2^{nd}) occurrence.

I understand that I will be charged a No-Show and/or Late Cancellation fee of 100% of my scheduled service if I fail to give at least 24 hours notice prior to cancelling or not showing up for my appointment on the third (3^{rd}) occurrence and that ALL future appointments will be required to be 100% Pre-Paid for.

I have read, understand and agree to this No-Show and Late Cancellation Policy.

_____

Client Signature Date

_____

Massage Therapist Signature Date

OFFICE USE ONLY:

___MC ___ PAT. INFO

___BWK ___ Calendar ___File ___ Forms

___ 5WM