

MASSAGE THERAPY

client intake form

CLIENT INFORMATION :

First Name:	Last Name:
Date of birth:	Referred by:
Address:	
City:	Postal Code:
Email Address:	
Mobile Phone:	Home Phone:
Emergency Contact Name:	Emergency Phone:
Physician's Name:	Physicians's Phone:
Date of Initial Visit:	

M E D I C A L H I S T O R Y

How would you rate your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

List current medications & the conditions they are treating?

List any major accidents or surgeries (including dates)

Please tell us about any allergies or hypersensitivities

Reason for initial visit

Please mark any of the following conditions you currently have.

HEAD / NECK:

- ☐ Headaches / migraines
- ☐ Ringing in ears
- ☐ Vision problems
- ☐ Vertigo / dizziness
- ☐ Hearing loss
- ☐ Vision loss

RESPIRATORY

- ☐ Asthma
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Frequent colds
- ☐ Shortness of breath
- ☐ Sinusitis
- ☐ Smoker
- ☐ Family history of
- ☐ respiratory difficulties

REPRODUCTIVE

- ☐ Pregnant
- ☐ Gynecological problems
- ☐ Given birth

NERVOUS SYSTEM

- ☐ Sensory loss / change
- ☐ Sciatica
- ☐ Seizures
- ☐ Numbness / tingling
- ☐ Epilepsy
- ☐ Multiple sclerosis

MUSCULOSKELETAL SYSTEM

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Bursitis
- ☐ Family history of arthritis
- ☐ Jaw pain (TMJ)
- ☐ Tendonitis
- ☐ Pins / plates / wires / artificial joint

SKIN & INFECTIONS

- ☐ Hepatitis
- ☐ Herpes
- ☐ Lyme disease
- ☐ HIV / AIDS
- ☐ Tuberculosis
- ☐ Infectious skin conditions

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Heart attack
- ☐ Heart disease
- ☐ Phlebitis / varicose veins
- ☐ Hemophilia
- ☐ Stroke
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Pacemaker
- ☐ Chronic congestive heart failure
- ☐ Family history of cardiovascular problems

OTHER

- ☐ Cancer
- ☐ Unexplained weight loss
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Psychiatric disorder
- ☐ Diabetes
- ☐ Digestive conditions
- ☐ Chronic fatigue syndrome
- ☐ Anxiety
- ☐ Other Conditions

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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 or 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.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law.

.....
Client Printed Name

.....
Client's Signature

.....
Date

.....
Therapist Name:

.....
Therapist Signature

.....
Date

MESSAGE INFORMATION

Have you had a professional massage before? (If yes, state the date of last treatment)

☐ Yes ☐ No

Are there any areas (feet, face, abdomen, etc.) you do not want massaged?

☐ Yes ☐ No If yes, please identify

Do you have any allergies to oils, lotions, or ointments?

☐ Yes ☐ No If yes, please identify

Is there a particular area of the body where you are experiencing tension, stiffness, pain or discomfort?

☐ Yes ☐ No If yes, please identify

Do you sit for long hours at a workstation, computer, or driving?

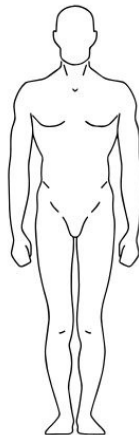
☐ Yes ☐ No If yes, please describe

Do you have any particular goals in mind for this massage session?

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

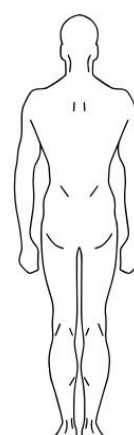
Front:



Right side:



Back:



Left side:



I acknowledge that the massage I receive is for relaxation and relief of muscular tension. If I feel any discomfort, I will inform the therapist immediately so that they can adjust the pressure and strokes to my comfort level.

I understand that massage is not a substitute for medical examination or treatment, and I should consult a doctor for any physical or mental health issues. I confirm that I have disclosed all known medical conditions and will update the therapist on any changes. I acknowledge that the therapist is not liable if I fail to do so.

.....
Client Printed Name

.....
Client's Signature

.....
Date

CLIENT CONSENT

client intake form

Client Name:

Date of birth:

SCOPE OF PRACTICE

Massage Therapy is a profession in which the practitioner applies manual techniques, and may apply adjunctive therapies, with the intention of positively affecting the health and well-being of the client. Massage Therapists do not diagnose or prescribe for medical conditions nor are they allowed to provide treatment for a specific condition without a doctor's supervision. The massage therapist is required to refer you for diagnosis and to follow recommendations of your physician.

EXISTING AND NEW MEDICAL CONDITIONS

It is the responsibility of the client to keep the massage therapist informed of any medical treatment currently being taken, and to provide written permission from the physician, chiropractor, physical therapist, etc., that the massage may be continued. The client must also keep the massage therapist informed of any changes in health conditions. For clients undergoing chemo and radiation therapies - If you are currently in treatment, or if your last treatment session was less than 12 months ago, we require a doctor's note that states the doctor is aware of and agrees to the desired treatment.

INFORMED CONSENT

I understand that the massage therapy I receive is provided for the purpose of relaxation and relief of muscular tension. I acknowledge that the therapist will use various techniques to address my specific needs and that I am free to communicate with the therapist regarding the pressure and/or strokes used. I understand that massage therapy is not a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of.

By signing below, I acknowledge that I have read and understand this Massage Therapy Client Consent Form, and I give my informed consent to receive massage therapy from the therapist named below.

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Client Printed Name

.....
Client's Signature

.....
Date

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Therapist Name

.....
Therapist Signature

.....
Date

C A N C E L L A T I O N

policy form

We are committed to providing all of our clients with exceptional care in a timely manner. For this reason, we have instituted a 24 hour cancellation policy for all appointments.

We understand that sometimes life gets in the way and appointments need to be rescheduled or canceled. However, we kindly ask that you provide at least 24 hours' notice if you need to cancel or reschedule your appointment. This allows us to offer the time slot to another client who may be waiting for an appointment.

If you need to cancel or reschedule within 24 hours of your appointment, a fee of the service cost will be charged. If you do not show up for your appointment and do not provide any notice, the full cost of the service will be charged.

If you are late we reserve the right to cut your service, you will be charged for the service you booked not the cut service. If you are more than 15 minutes late and we do not have enough time to perform the service due to timing, you will be charged in full.

We appreciate your understanding and cooperation in following our cancellation policy. Our goal is to provide the best possible service to all of our clients, and this policy helps us achieve that goal by ensuring that our estheticians' time is used efficiently and effectively.

I have read this policy and understand that I need to provide at least 24 hours notice when rescheduling or cancelling an appointment. If I fail to contact the office at least 24 hours in advance, I will be charged the appropriate cancellation fee.

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Client Printed Name

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Client's Signature

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Date

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LMT Name

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LMT Signature

.....
Date