New Patient Client Intake Form

Personal Information:

Name _____ Phone _____

Address _____

City/State/Zip_____

Email _____ Date of Birth _____ Occupation _____

Massage Information

How did you hear about me? _____ Is this a gift certificate?_____

Have you ever experienced a professional massage or bodywork session? _____

What is your primary issue/concern that brings you in today_____

Medical History

Please take a moment to carefully read the following information. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

- ☐ heart disease
- ☐ asthma/emphysema/shortness of breath
- ☐ high/low blood pressure
- ☐ malignancy
- ☐ auto immune disorder
  - Please list:_____
- ☐ mental illness
  - Please list: _____
- ☐ DVT
- ☐ Epilepsy
- ☐ Celebral Palsy
- ☐ Stomach ulcers
- ☐ Diabetes
- ☐ Thyroid imblanaces
- ☐ Cardiovascular disorder
  - Please list: _____
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ TBI
- ☐ Chronic Fatigue Disorder
- ☐ Cancer
  - Type:_____
  - Location:_____
- ☐ Joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
- ☐ Parkinson's disease
- ☐ TMJ
- ☐ Osteoprosis
- ☐ Carpal Tunnel Syndrome
- ☐ Circulatory Disorder
  - Please list:_____
- ☐ Multiple sclerosis
- ☐ Peripheral neuropathy
- ☐ Vascular disease
- ☐ Insomnia
- ☐ Depression
- ☐ Allergies
  - Please list:_____
- ☐ Headaches
- ☐ Migraines
- ☐ Pregnancy
  - How many months?_____
- ☐ Hormonal irregularities
  - Please list:_____
- ☐ Other:_____

_____

Please list any prior accidents or injuries.

_____

_____

_____

Please list any prior surgeries (including dental).

_____

_____

_____

Please list medications currently taking.

_____

_____

I understand that the massage therapy I receive is provided for the basic purpose of relaxation & relief of muscular tension. If any pain or discomfort is experienced during this session, I will immediately inform the therapist so that the pressure and/or strokes can be adjusted to my level of comfort. 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 diagnose, prescribe, or treat any physical or mental illness. As massage should not be performed under certain medical conditions, I affirm I have been honest and forthcoming regarding my medical conditions. I agree to keep the therapist informed of any medical profile changes and there will be no liability on the therapist's part if I fail to do so.

Cancellation Policy: Please give 24 hours' notice for cancellations. Expect in emergencies, appointments cancelled less than 24 hours will be charged the full session fee.

Signature of Client_____ Date _____

Signature of Massage Therapist_____ Date_____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____