MASSAGE THERAPY CLIENT INTAKE FORM

Name: _____ Phone:(_____)_____

Cell Phone: (____)_____ Date of Birth_____

Address:_____Apt.#_____

City:_____ State:_____ Zip:_____

Email: _____

In case of emergency contact:_____Phone(___)_____

Relationship to emergency contact_____ Referred by:_____

Your Occupation _____ Your Physician _____

Please take a moment to carefully read the following information and sign where indicated. 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.
All client information is strictly confidential. The information you provide on this intake form is used only by me to better understand and serve the needs of my client. Furthermore, the Texas Department of State Health Services requires a consultation/intake form on every massage client.

Have you ever experienced a professional massage or bodywork session? ☐ Yes ☐ No

If yes, how recently? _____ **What is your major complaint or condition you want to improve:**_____

What are your intentions or expectation for this visit?_____

What kind of pressure do you prefer? ☐ light ☐ medium ☐ firm

*Please **check** the box if you have any of the following:*

☐ Suffer from Stress?_____ ☐ Low Back Pain?_____

☐ Muscle Spasms? _____ ☐ Neck Pain?_____

☐ Pinched Nerve?_____ ☐ Herniated Disks?_____

☐ Tension or soreness in a specific area?_____

☐ Arthritis?_____ ☐ Cancer?_____

☐ Diabetes?_____ ☐ Bruise Easily?_____ ☐ Broken bones in the past two years?

_____***Please check the box if you have any of the following:***

☐ Pregnant?_____ ☐ Cardiac or Circulatory Problems?_____

☐ Pace maker? _____ ☐ Joint Replacements?_____ ☐ Varicose Veins?_____

☐ Wearing dentures or eye contacts lenses?_☐ High blood pressure?_____☐ Taking medications for it?___

☐ Numbness or stabbing pains?_____ ☐ Suffer from epilepsy or seizures?_____

☐ Sensitive to touch or pressure in any area?_____

☐ Suffer from joint swelling?_____ ☐ Osteoporosis?_____ ☐ Allergies?_____

☐ Any contagious diseases?_____ ☐ History of surgeries? _____

☐ Other medical conditions?_____

☐ Are you taking any medications I should know about?_____

Additional comments regarding your health and well-being:_____

_____

_____

Payment Policy

I, the undersigned, understand and acknowledge that payment for all care received is my responsibility. Payment is due at time of services unless other arrangements have been made in advance with the massage practitioner. Skillful Touch Massage accepts cash or checks. I also understand that more than 24-hours advance notice of cancellation or rescheduling is necessary to avoid late charges.

Massage Therapy Informed Consent

I, the undersigned, understand that the massage/bodywork I receive is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork 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 of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I

also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I have received a copy of the therapist's policies, I understand and agree to abide by them.

_____ _____

Client's Signature **Date**

_____ _____

Massage Therapist's Signature **Date**

☐ **YES I WOULD LIKE TO BE ON YOUR EMAIL NEWSLETTER LIST**
TO RECEIVE
VALUABLE MASSAGE PROMOTIONS
&
HEALTHY LIVING TIPS!!