

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 are your short term or long terms goals working with me? _____

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 and checks. I also understand that more than 24 hours cancellation and rescheduling notice is necessary to avoid last minute/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
&
HEALTHY LIVING TIPS!!**