CLIENT INTAKE FORM

Name:	Date of Birth:
Address:	
E-mail:	Phone:
When was the last time you received professional massage/bodywork? What types of massage have you received (Swedish, Deep Tissue Massage, Sports Massage, etc.): What are your goals/expected outcomes for receiving massage/bodywork?	
Have you ever had surgery? (*if yes please explain)* Select... Are there any special needs due to these circumstances? (e.g. extra bolstering, table positioning) Select...	
List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):	
Do these symptoms/issues interfere daily activities (e.g., sleep, exercise, work, childcare)? Select... *(If yes, please explain):*	
List the medications you currently take:	
Occupation (if retired what did you do?):	
Please take a moment to read the following information and sign where indicated. If you have a specific medical condition or symptoms massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided. Turn over	

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If you answer yes to any of the following questions, please explain why as clearly as possible.

Do you frequently suffer from stress?	Select...	Do you bruise easily?	Select...
Do you have diabetes?	Select...	Any broken bones in the past 2 years?	Select...
Do you experience frequent headaches?	Select...	Any possible complications/medications? (e.g. discomfort while lying flat, rescue inhaler) *If yes, please explain:*	Select...
Are you pregnant? *Massage is only to be administered 2nd trimester & beyond; no deep work is done during pregnancy*	Select...		
Do you suffer from arthritis?	Select...	Do you have any cardiac or circulatory problems?	Select...
Do you have any allergies? *If yes, please specify:*	Select...	Do you have any numbness?	Select...
Do you wear dentures?	Select...	Do you have any stabbing pains?	Select...
Do you have high blood pressure? *If yes, is it treated?*	Select... Select...	Do you have any radiating pains? *If yes, please specify:*	Select...
Do you suffer from epilepsy or seizures?	Select...	Sensitivity to touch/pressure anywhere? *If yes, please specify:*	Select...
Do you suffer from joint swelling?	Select...	Do you have varicose veins?	Select...
Are you wearing contacts?	Select...	Do you have osteoporosis?	Select...

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. Should I experience any pain or discomfort during the session I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I am aware that massage/bodywork should not be used as a substitute for medical examination, diagnosis or treatment and I should seek a qualified specialist for any ailments of which I am aware. I further understand that massage/bodywork practitioners are not qualified to perform skeletal or spinal adjustments or to treat any physical or mental illness, and that nothing said during the session should be construed as such. I am aware that massage/bodywork should not be performed under certain medical conditions and I affirm that I have stated all known medical conditions and answered all questions honesty. 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 by me will result in termination of the session and I will be liable for the entirety of the massage/bodywork session.

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

Consent to treatment of a minor: By my signature below, I hereby authorize massage/bodywork techniques to my child/dependent as they deem necessary. Signature Parent/Guardian: _____