New Patient Intake Form- Therapeutic Massage

Personal Information:

Name ________________________________ Phone _______________________________

Address ____

City ______________________State ______________ Zip ____________________________

Email address ______________________ DOB __________ Occupation ________________

Emergency contact _________________________ Phone number ______________________

As of May 1, 2016, we are requiring that ALL appointments are held with a credit card number.

We do require a 24-hour notice for all cancellations and you will be charged a $50 cancellation fee if you do NOT cancel within 24-hours of your scheduled appointment.

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Date of initial visit ____

1. Have you had a professional massage before? Yes No
   If yes, how often ____
2. Do you have any difficulty lying on your front, back or side? Yes No
   If yes, please explain ____
3. Do you have any allergies to oils, lotions or ointments? Yes No
   If yes, please explain ____
4. Do you have sensitive skin? Yes No
5. Are you wearing contact lenses, dentures or hearing aid? Yes No
   If yes, please describe ____
6. Do you sit for long hours at w workstation, computer or while driving? Yes No
   If yes, please describe ____
7. Do you perform any repetitive movement in your work, sports or hobby? Yes No
   If yes, please describe ____

8. Do you experience stress in your work, family or other aspects of life? Yes No

   If yes, how do you think it has affected your health? ________________________

   Muscle tension ( ) Anxiety ( ) Insomnia ( ) Other_________________

9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or discomfort? Yes No

   If yes, please identify ____

10. Do you have any particular goals in mind for this session? Yes No

    If yes, please explain ____

Medical History:

In order to plan a safe and effective massage session I will need some general information about your medical history.

11. Are you currently under medical supervision? Yes No

    If yes, please explain ____

12. Do you see a chiropractor? Yes No

    If yes, please list ____

13. Are you currently taking any medication? Yes No

    If yes, please list ____

14. Please check any conditions listed below that apply to you:

( ) Contagious skin condition ( ) Phlebitis

( ) Open sores or wounds ( ) Deep vein thrombosis/blood clots

( ) Easy bruising ( ) Joint disorder/rheumatoid arthritis

( ) Osteoarthritis/tendonitis ( ) Recent injury or accident

( ) Osteoporosis ( ) Recent fractures

( ) Epilepsy ( ) Recent surgery

( ) Headaches/migraines ( ) Artificial joint

( ) Cancer ( ) Sprains/strains

( ) Diabetes ( ) Current fever

( ) Decreased sensation ( ) Swollen glands

( ) Back/neck problems ( ) Allergies/sensitivity

( ) Fibromyalgia ( ) Heart condition

( ) TMJ ( ) High or low blood pressure

( ) Carpal tunnel syndrome ( ) Circulatory disorder

( ) Tennis elbow ( ) Varicose veins

( ) Atherosclerosis ( ) Pregnant If yes, how far along?

Please explain any conditions that you have marked above:

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____
____

15. If there is anything else about your health history that might be useful for your massage practitioner to know ahead of time?

    ____
    ____

Draping will be used during the session- only the area being worked on will be uncovered. Clients under the age of 17, must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, ____________________________ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the massage therapist so that the pressure and or strokes may 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 specialists for any mental or physical ailment that I am aware of. I understand that massage therapists 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 this session should be construed as such. Since massage should not be performed under certain medical conditions, I affirm that I have stated all known medical conditions and have answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client ____ *Date* _____________

Signature of Massage Therapist ______________________________ *Date* ____________