Calming Comfort Massage Therapy- Client Intake

Date _____

Name _____
Date of birth _____
Mailing Address_____
Email _____
Phone number _____Emergency contact _____

Occupation _____

Referred by _____
May I thank them for referring you? Yes/No

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

Have you had professional massage before? Yes/No
How recently?

Do you have an allergies or skin sensitivities to oils or lotions? Yes/No
If so, please explain:

Are you wearing:
Contact lenses Yes/No
Hearing aids Yes/No

Do you sit for long hours at a workstation, computer or driving? Yes/No

Do you have any particular goals for this massage session? Yes/No
If yes, please explain:

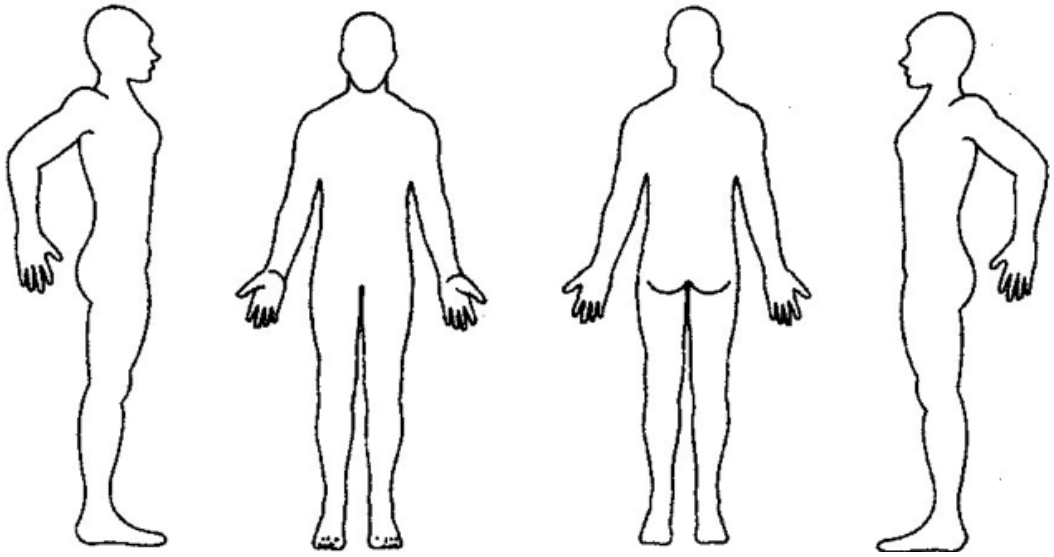
Are you currently taking any medications, prescription or over-the-counter? Yes/No
If yes, please list:

Please circle any condition below that applies to you:

Varicose veins	Depression	High or low blood pressure
DVT/blood clots	Heart condition	Easy bruising
Circulatory issues	Artificial joint	Diabetes
Headaches/migraines	Numbness	TMJ
Recent surgery	Recent injury	Osteoporosis
Epilepsy/seizues	Anxiety	Osteo or rheumatoid arthritis

Are you pregnant? Yes/No If so, how long? _____
Please explain any condition you circled above:

Is there anything else about your health history that you think would be useful for your massage therapist to know?
Please circle any specific areas you would like the massage therapist to concentrate on during the session:



Consent for Treatment

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 should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware.

I understand that massage 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 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.

Understanding all of this, I give my consent to receive care.

Client signature _____

Therapist signature_____

Date_____