Massage & Wellness Intake Form

Please fill out all information as accurately and thoroughly as possible.
It is the better that you give us what you consider too much information, rather than not give us enough information.

Name: _____ Email: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone # Work: _____ Home: _____ Cell: _____

Occupation: _____ Date: of Birth: _____

If Student, course of study: _____ Approx. Completion Date: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

How did you hear about us? _____Height: _____ Weight:_____

Have you ever received professional massage or bodywork before: _____

What (specifically) would you like to receive from your appointment today? _____

Would you like me to focus on or target any specific areas today? _____

Would you like me to stay away from any specific areas? _____

FOR FACIALS ONLY:

Skin type do you have: Dry: _____ Oily: _____ Acne Prone: _____ Sensitive: _____Combination:_____

What (specifically) would you like to receive from your facial today? _____

HEALTH INFORMATION

Are you or have you ever had any of the following conditions (Please check yes or no).

	Yes	No		Yes	No		Yes	No
Smoker?			Pregnant?			Contagious Disease?		
High Blood Pressure?			Allergies?			Heart Conditions?		
Low Blood Pressure?			Seizures?			Diabetic?		
Epilepsy?			Varicose Veins?			Cancer?		
Frequent Headaches?			Dementia?			Frequent Anxiety?		
Nausea?			Skin Conditions?			Surgeries?		

Please explain any yes answers: _____

_____

_____

Are you currently suffering from pain related to traumatic experience (i.e.: car accident, sports injuries, surgeries) Y / N

If yes, briefly explain (what and when): _____

_____

Are you currently taking any medications or supplements (prescription and non-prescription) Y / N If yes list names & dosage of all medications: _____

_____

I attest that the above information is true and accurate to the best of my knowledge

Signature: _____ Date: _____ Therapists Initials: _____

If minor, signature of guardian required: _____ Date: _____

Disclaimer: By signing above, I agree that I understand that a massage therapist is not a doctor and cannot prescribe medication or diagnose medical conditions. The therapists does not discriminate on the basis of race, religion, age, gender and sexual preference.

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my perso nal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain informatio n pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Client Name _____ Signature of Client/Guardian _____

Date Signed _____