

Massage Center

Client Intake form

Name _____ Telephone _____
Address _____ City _____ Zip _____
Emergency contact _____ Telephone _____
Do you want to be notified of our massage specials? Email address _____
Physician's name _____ Telephone _____
Occupation _____ Age _____ Male Female
How did you hear about us? _____
Have you ever received a professional massage? Yes No How recently? _____
Special preferences for massage _____

Check all of the conditions which apply to you and explain clearly in the space provided below:

* 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.

- | | | |
|---|--|--|
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Herniated/ruptured/bulging disc | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Heart/circulatory problems | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sharp/stabbing pain | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Contagious disease | <input type="checkbox"/> Mental/emotional disorder | <input type="checkbox"/> Chronic Fatigue |

Explain all major health conditions, injuries, surgeries, and chronic conditions:

List medications you are currently taking (including, aspirin, ibuprofen, muscle relaxants...):

Please read the following information carefully and sign where indicated:

I understand that the massage/bodywork I receive is for the purpose of basic relaxation and relief from muscular tension. If I experience any pain or discomfort during a session, I will immediately inform the practitioner so that pressure-strokes may be adjusted to my comfort level. I understand that massage/ bodywork is not a substitute for medical examination, diagnosis, or treatment, and that I should see a qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork practitioners are not qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because certain conditions and symptoms are contraindicated to massage/ bodywork, 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 or the school should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in the immediate termination of the session, and that I will be liable for full payment of the scheduled appointment.

Client Signature _____ *Date* _____

Consent to Treatment of Minor: By my signature below, I hereby authorize the student massage practitioner to administer massage/bodywork techniques to my child or dependent as they deem necessary.

Parent/Guardian Signature _____ *Date* _____