Massage & Reflexology - Intake Form - CONFIDENTIAL INFORMATION

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_ State \_\_\_ Zip Code \_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ relationship to you \_\_\_\_\_\_\_\_\_

 (Name and Phone #)

Did anyone refer you? Please give their name so we can thank them \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Name and Phone #)

Have you ever received massage therapy? Yes No

What are your expectations today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have sensitivity to scents or essential oils? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies to foods/medications/environment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any areas you prefer to be avoided during a massage (head/feet) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking & reason for medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you currently seeing a healthcare professional? Yes No

If yes, please list reason for treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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The following sometimes occurs during your treatment. You may need to move or change position. You may find yourself sighing, yawning, or a change in your breathing. Your stomach may gurgle or have intestinal movement. You may feel emotional: irritation, laughter, happy, sad, ect. You may experience energy shifts, fall asleep, have memories. They are normal responses to relaxation. Trust your body to express what it needs to.

Please review this list and check those conditions that have affected your health either recently or in the past.

Circle all that apply:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Anemia | \*Carpal tunnel | Depression | \*Muscle strain/sprain | Scoliosis |
| Allergies | Cancer | Diverticulitis | \*Neck pain/problems | Seizures |
| \*Arthritis | Chemical dependency (alcohol, drugs) | Fibromyalgia | \* Nerve Damage | Stroke |
| \*Accident-date | Chronic Fatigue | Headaches | \*Over-Use Injury | \*Surgery |
| \*Diabetes- type | \*Circulatory Condition | Heart conditions | \*Plates/Pins | \*Skin conditions |
| Blood clots | Compromised Immune System | High/Low blood pressure | \*Pain: chronicStabbingShooting | TMJ/Teeth Grinding |
| \*Broken/dislocated bones | \*Dizziness | HIV/AIDS | Panic disorder | Tuberculosis |
| Bruise easily | Eczema | Liver Disorder | Pregnancy | Varicose Veins |
| Back problems | \*Disc or Spine issues | Lupus | Planter Fasciitis | \*Whiplash |
| \*Bone condition | \*Digestive disorders | Kidney Dysfunction | \*Sciatic pain |  |

If any of the above needs to be detailed or if there is anything else to share, please do so:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.

2. This is a therapeutic treatment and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.

3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions I understand that if I experience any pain or discomfort during my session, I will immediately inform the therapist. I also understand that massage should not be considered a substitute for medical examination, diagnosis or treatment and I agree to seek qualified medical care for any mental or physical illness that I am experiencing. I recognize that massage therapists are not qualified to diagnose, treat or prescribe for illness or injury and I will request a referral if such is required. I also understand that certain contraindications exist for massage therapy and I will inform my massage therapist immediately if any changes to my health profile occur. I agree that my massage therapist will not be held liable for any negative effects if I fail to update my profile or provide complete information.

4. I give permission to be contacted by email or phone, sms/text for appointment confirmation and reminders, as well as newsletters, announcements and events.

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 Signature Date

Parent Signature (required if client is under 18): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_