4 Essential Balance LLC
Edgewood, NM 87015
4essentialbalance@gmail.com
www.4essentialbalance.com

Massage Intake

Today's date: _____

Legal Name: _____ Preferred name: _____

Mailing Address: _____

Email: _____ Cell Phone _____
Do you receive text/sms ☐ Yes ☐ No

Home telephone number: _____ Birthdate: _____

Occupation: _____

Whom may we thank for referring you? _____

Primary Care Physician: _____
(Name and Phone #)

What are 1 -2 problem areas you would like to work on today? _____

Do you have any other issues that bother you on a regular basis? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Health History

Please check the following conditions that apply to you, whether past or present

Musculoskeletal

o Headaches	o Shoulder/neck pain	o Bursitis
o Joint stiffness	o Arm/hand pain	o Osteoarthritis
o Spasms/cramps	o Leg/foot pain	o Rheumatoid arthritis
o Broken bones	o Chest/abdominal pain	o Scoliosis
o Sprains	o Jaw pain/TMJD	o Bone or joint disease
o Back/hip pain	o Tendinitis	o Trouble walking
o joint replacement	o old breaks or injuries	

Circulatory and Respiratory

o Dizziness	o Heart failure	o pacemaker
o Shortness of breath	o Heart attack	o High blood pressure
o Fainting	o Sinus issues	o Low blood pressure
o Swollen ankles	o Asthma	o Varicose veins
o Blood clots	o Seasonal allergies	o Lymphedema

Skin

o Rashes	o Ulcers	o Acne
o Allergies	o Warts	o Cosmetic surgery
o Fungal infection	o Moles	o Chemical sensitivity

Nervous system

o Numbness/tingling	o Fibromyalgia	o Herpes/shingles
o Migraines	o Paralysis	o Benign tremor
o Chronic pain	o Epilepsy	o Cerebral palsy
o Stroke	o MS/MD /Parkinson's	o Brain/spine injury

Other _____

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Please READ and check all boxes. Signing this document affirms you have read and agree to all items.

- ☐ I, _____, (client) understand that massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, and offer a positive experience of touch.
- ☐ I understand that the therapist does not diagnose illness, does not prescribe medication, and that spinal manipulation is not part of massage therapy.
- ☐ I understand that certain contraindications exist for massage therapy, and I will inform my massage therapist immediately if there are any changes to my health.
- ☐ Minors under 18 years may not receive services unless a guardian has given written permission and is present.
- ☐ Clothing: I understand I may choose to leave on as much clothing as I wish. I will receive an effective massage whatever I choose.
- ☐ The client will always be modestly draped. Only the area being massaged will be undraped.
- ☐ I affirm that I have answered all questions regarding my medical conditions and will inform the therapist immediately if I experience any pain or discomfort during the session.
- ☐ I understand that massage therapy is not a substitute for medical examination, diagnosis, or treatment. I will seek qualified medical care for any physical or mental health concerns. I recognize that massage therapists are not qualified to diagnose, treat, or prescribe for illness or injury.

Please list all prescription and Nonprescription drugs/supplements, including alcohol/nicotine use:

_____

_____

History of car accidents, falls, concussions, whiplash injuries, serious illnesses: Date(s) Incident

_____ _____ _____

In general, how is your health? _____

What are your major stressors? _____

Any history of cancer? _____

Have you had any surgeries? Date(s) Surgery _____

_____

Are there any other concerns? _____

By signing this document, I certify that I have read and understand the above statements from all pages and consent fully and am in full agreement to the terms and conditions in their entirety and will abide by the all policies.

_____ _____
(signature) (date)

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