MASSAGE INTAKE FORM Date_____

NOTE: THE FOLLOWING INFORMATION IS COMPLETELY CONFIDENTIAL AND IS USED FOR ANALYSIS ONLY. THIS PROFILE SHOULD BE COMPLETED BY ALL CLIENTS SO THAT I MAY CORRECTLY EVALUATE YOUR SPECIAL NEEDS FOR BODYWORK AND FOR HOME MAINTENANCE. FOR YOUR SAFETY, I MUST ALSO BE AWARE OF ALL MEDICAL CONDITIONS THAT HAVE BEEN DIAGNOSED. THERAPEUTIC MASSAGE MAY IMPACT THESE AND YOUR HEALTH.

THANK YOU FOR TAKING THE TIME TO TELL ME ABOUT YOURSELF!

Name_____Address_____

City_____State_____Zip_____Home#_____Cell#_____

Work#_____ DOB____ /____ /_____ Email_____

Occupation_____

Work Activity □ Phone □ Computer □ Lifting □ Sitting □ Standing □ Driving

Who Referred You?_____

Emergency Contact_____Phone#_____

GENERAL INFORMATION

Do you have any specific area you would like to be addressed?_____

Are you under a physicians care?_____
If so, please provide your physicians name and phone number_____

Do you have an infection, fever, or are you taking antibiotics?_____

Are you taking any of the following medications (please circle all that apply):
♦blood pressure ♦blood thinners ♦pain medication ♦muscle relaxers ♦anti-depressants
♦anxiety medication ♦anti-inflammatory ♦antibiotics
Please list any other medications:_____

Do you have any recent injuries, or old injuries still affecting you?
_____
_____

Please list surgeries in the past 6 months_____

Please list any other medically diagnosed conditions(i.e. Diabetes, cancer, pacemaker, etc.)
_____

associated therapeutics INCORPORATED

CLIENT AGREEMENT

Because the Massage Therapist needs to be aware of any existing conditions that I have, I have listed all of my known medical conditions and physical limitations and will inform the Therapist of any change in my health. I understand that the purpose of my massage session is for stress reductions, relief from muscular tension, and/or for increasing circulation and energy flow. I understand that a Massage Therapist does not diagnose illness, disease, or any physical or mental disorder, nor prescribe medical treatment, pharmaceuticals, or perform spinal manipulation. I acknowledge that massage therapy is not a substitute for medical examination or diagnosis, and that it is recommended that I see a Primary Health Care provider for that service.

I understand that the information I provide is confidential and will be shared only with written consent. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment for the full scheduled appointment.

Should I need to cancel future sessions, I agree to give 12 hours notice, and I also understand there will be a $25 charge for any missed appointments where I failed to call beforehand.

Client or Parent (if under18) signature:_____Date_____