Massage Therapy Intake Form

Name_____Birthdate mm____/dd____/yy_____Date_____

Address_____City_____ Postal Code_____

Occupation_____E-Mail_____

Phone(H)_____(W)_____(C)_____

What is the reason for this appointment?_____

Who referred you ? _____Have you had a massage before?_____

If yes, what did you enjoy about your last massage?_____

What did you dislike?_____

Please list any pertinent illnesses/surgeries/ or accidents within the last ten years

_____

_____

_____

Are you currently taking any medication? Please list.

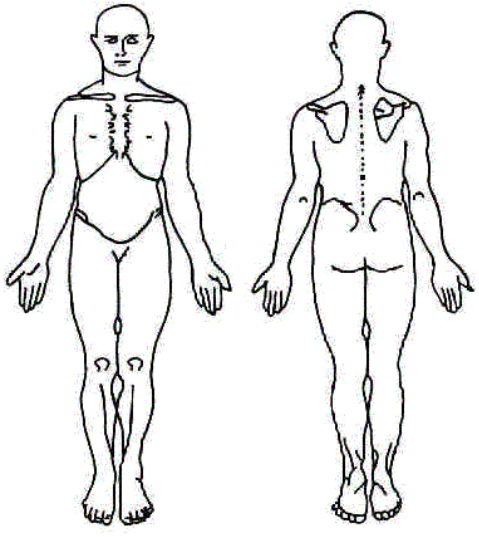
_____

_____

Have you now, or previously been affected by any of the following conditions. Please circle.

Allergies	Insomnia	Edema	Fatigue
Cancer	Diabetes	Parkinson	M.S.
Polio	Scoliosis	Migraines	Headaches
Torticollis	Whiplash	Heart attack	High Blood Pressure
Arthritis	Sciatica	Stress	Low Blood Pressure
Bursitis	Tendonitis	Back Pain	Swollen feet/legs
Sprains	Strains	Joint problems	Muscle tension
Neck Pain	Poor Circulation	Tingling/Numbness	Fibromyalgia
TMJ	Carpal Tunnel Syndrome		Thoracic Outlet Syndrome

On the drawing below, please indicate any areas of pain/discomfort. Please describe, or circle.



See Reverse

Please indicate if you are experiencing any of the following conditions.

Pregnancy(how many weeks)_____Flu or cold__Infection____Inflammation____Headache____Migrane___

What is your main area of concern?_____

When and how did this condition occur?_____

What, if any, treatment have you received for this condition?_____

Do you have sleep difficulties ?_____

How often do you exercise?_____What kind?_____

Waiver of Liability

I understand that massage therapy is given for the purpose of stress reduction, relief from muscular tension, spasms, or pain to increase blood and lymph flow, and to increase joint mobility.
The massage therapist does not diagnose or prescribe for medical illness or disease, or any other physical or mental disorders. The massage therapist does not do spinal manipulation or examinations of the spine.

I understand and do hereby release and waive the massage therapist of any and all liability, including: muscle soreness, bruising, discomfort, headache, bone fractures, illness or disorder, contraction of disease, discomfort, pain or suffering that may arise at the time of, or thereafter result from aforesaid services in the nature of massage therapy.

This shall be my good and sufficient authority to provide aforesaid services to you without fear or threat of claims or lawsuits arising from the services provided. I understand that the above information will assist the therapist with massage therapy treatment and hereby certify the above information to be true. I will take it upon myself to inform the massage therapist of any changes in my physical health.

****** I understand that payment is expected at the time of treatment and that a current credit card will be kept on file.******

Credit Card #_____VCode#_____Expiry_____

We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all of our clients and out of consideration for our therapists' time, we have adopted the following cancellation policy:

24 hour advance notice is required when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment, or we can fill someone on the wait list.
If you do not provide 24 hours advance notice or are a No-Show for your appointment, you will be charged the full appointment fee. This amount will be automatically charged to the credit card on file.

Signature_____Date_____

Print Name_____