Client Information/Health Intake Form

Full Name:_____ Date of birth_____

Address:_____ Email:_____

City/St:_____Zip:_____ Occupation:_____

Cell Phone:_____ How did you hear about me?_____

Emergency Contact Name/number:_____

Have you ever received professional massage?_____ How frequently?_____

What type of pressure do you prefer? Light_____ Medium_____ Deep_____

Are there any areas you would like to be avoided?_____

Any known allergies?_____

Please list any accidents and/or surgeries in the past five years_____

_____

Please list any medications, herbs, or supplements you are currently taking:_____

_____

Please check any of the following that apply to you now or in the past:

__Fibromyalgia	__Diabetes	__Sciatica	__Heart Attack
__headache/migraines	__Osteoporosis	__Plantar Fasciitis	__Numbness/tingling
__Carpal Tunnel	__Rheumatoid Arthritis	__Gout	__Physical/Emotional Abuse
__TMJ	__Bursitis	__Cancer	__Low Blood Pressure
__HBP	__Blood Clots	__Pregnant	__PMS
__Hepatitis	__HIV/AIDS	__Rashes	__Insomnia

I understand that massage services are designed to be a health aid and in no way takes the place of a doctor's aid when indicated. Any information exchanged during a massage session is considered educational in nature and is intended to help you become more conscious of your health. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a qualified medical specialist for any ailment of which I am aware. I understand that massage therapists are NOT qualified to diagnose and nothing said in the course of treatment should be construed as such. I affirm that all known medical conditions are listed and all questions were answered honestly. I agree to keep the therapist updated as to any changes in medical history or otherwise, and understand that there shall be no liability on the therapists part should I fail to disclose any new information. I also understand that any illicit or sexually suggestive behavior or remarks shall result in termination of the session and I am liable for full payment due for scheduled appointment.

Cancelations require a 24 hour notice with the exception of emergencies. **Same day cancelations/no shows are liable for the full amount of scheduled appointment.**

___Please check here indicating you have read and agree to this policy

Signature_____ Date:_____

(Parent signature is required for minors)