Essential Therapeutic Massage Client Intake Form

Name____ **Occupation**________________________

Address____ **Email**___________________
City State Zip Code

Date of Birth________________ **Best Contact Phone (Cell or Home?)** _________________________

Emergency Contact____
Name Relationship Phone Number

Name of Referral/ How You Found the Massage Center_______________________________________

Recent/past injuries, traumas, accidents or medical treatments: ___________________________________

Are you currently under the care of a Chiropractor, Physical Therapist, or Physician for an ongoing issue?
No ____ Yes_____ (Brief explanation) ____

Please check/circle all of your following current/past conditions and specify details, dates and where:

Musculo-Skeletal & When
- ☐Arthritis________________
- ☐Back or Neck pain_______
- ☐Broken or Fractured bones: ________________________
- ☐Bursitis _______________
- ☐Chest/Rib/Abdominal pain
- ☐Disk Herniation_________
- ☐Dislocation______________
- ☐Headaches / Migraines ___
- ☐Hip/Leg/ Foot pain ______
- ☐Jaw pain / TMJ Disorder__
- ☐Plantar Fasciitis_________
- ☐Osteopenia______________
- ☐Osteoporosis___________
- ☐Problems walking_______
- ☐Scoliosis________________
- ☐Shoulder /Arm /Hand pain
- ☐Spasms/Cramps_________
- ☐Tendinosis_____________
- ☐Wrist/Ankle pain________

Auto-Immune Disorders
- ☐Crohn's Disease / IBS_____
- ☐Diabetes________________
- ☐Fibromyalgia____________
- ☐HIV/AIDs_______________
- ☐Lupus__________________
- ☐Lyme's Disease___________
- ☐Muscular Sclerosis________
- ☐Rheumatoid Arthritis______

Circulatory & Respiratory
- ☐Anemia_________________
- ☐Deep vein thrombosis (DVT)
- ☐Hardware _______________
- ☐Heart condition___________
- ☐High or Low blood pressure
- ☐Stroke (Date)____________
- ☐Varicose veins___________
- ☐Allergies_________________
- ☐Asthma__________________
- ☐Other____________________

Skin Problems & Disorders
- ☐Allergies___________________
- ☐Athlete's Foot
- ☐Rashes ____________________
- ☐Skin Disorder_______________
  - Location: ________________
  - Sensitive to touch?_________

Surgeries, When & Details
- ☐Abdominal/ Stomach / Hernia ___________________________
- ☐Arm/Hand/Wrist
- ☐Heart _____________________
- ☐Hip/Leg/Ankle/Foot ________
- ☐Implants/Fat Transfer_______
- ☐Joint (Specify)_____________
- ☐Lymph Node Biopsy/Dissect, Rad,Removal________________
- ☐Shoulder or Rotator Cuff_____ ___________________________
- ☐Spine/Fusion______________
- ☐Other______________________

Nervous System & Where?
- ☐Herpes/shingles___________
- ☐Numbness/tingling_________
- ☐Paralysis__________________
- ☐Other ____________________

Other, Diagnosis Date, Where
- ☐Burns ____________________
- ☐Cancer 1__________________
- ☐Cancer 2__________________
  - Chemo________Rad________
- ☐Hearing Impaired: Left Right
- ☐Hepatitis A B C____________
- ☐Lipo/Plastic surgery________
- ☐Pregnancy Due Date________
- ☐Swelling/Lymphedema______
- ☐Tuberculosis ______________
- ☐Tumor(s)_________________
- ☐Vertigo __________________
- ☐Visually Impaired: Left Right
- ☐Other______________________

Current Medications (or for what conditions are you taking the medication?): _____________________
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Massage Information:

Have you had a professional massage before? ☐ Yes ☐ No If yes, when was your last massage? _________________________

If yes, how often do you get massages? ______________________ Which type(s)____

Which is your preferred massage pressure/contact? ☐ Light ☐ Medium ☐ Firm ☐ Not Sure ___________________________

Are you sensitive to Essential Oils? ☐ Yes ☐ No Fragrances? ☐ Yes ☐ No If yes, specify: ____________________

Do you have sensitive skin? ☐ Yes ☐ No If only in specific areas, where? ____________________________________

Do you exercise regularly? ☐ Yes ☐ No How much water do you drink? _____________________________________

What are your common areas of concern, pain and/or tension? ____

Client Consent and Understanding of Services, Massage Sessions and Policies

- As we are working in a small and confined space, we have clients and therapists who have allergies and/or sensitivities to many common fragrances such as perfumes, colognes, body lotions, body sprays, smoke, etc. Please be mindful of others and *refrain from wearing* or try to limit your exposure to these the day of your session as these tend to linger in the common areas of the office affecting others even hours after sessions have ended. We thank you in advance! Please Initial _________

- I understand that massage therapy is for the purpose of stress reduction, relief from muscular tension and spasm, general relaxation, improvement of circulation and energy flow. To help with this process, during sessions, cell phones are off.

- I understand that Massage Therapy is in no way associated with any type of sexual implication. The Therapist reserves the right to **immediately terminate** any massage should the client engage in sexual innuendo, banter, propositioning, or touch. **The client will also be responsible for paying the full price of the appointment prior to leaving the facility.**

- I understand that the licensed massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical or pharmaceuticals, nor do they perform any spinal manipulations. It has been made very clear that massage therapy is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

- I have stated all my known medical conditions and take it upon myself to keep the licensed massage therapist updated on my physical health.

Late Arrivals, Cancellations and No-Show Policies

Please show your Licensed Massage Therapist the same respect you would of any Health Care Practitioner, if you are scheduled for a massage session, you are expected to arrive early to allow the session to start and end on time. Please be respectful of your reserved session time and of other clients booked afterwards as you would at your physician's office.

Arrival Time Policy
Arriving 10 minutes prior to your session start time will allow proper time for a brief treatment discussion prior to the session and to ensure that your session will begin on time. So that following clients are not inconvenienced, the session length will be adjusted for late arrivals at a full fee. Please complete all phone calls prior to entering our office as cell phones must be silenced.

Late Arrivals
If you arrive late, your session will end at the originally scheduled time to ensure the clients following your session are not inconvenienced or penalized. If you are more than 15 minutes late, your therapist will then determine if there is enough time remaining to start your treatment or if the session instead would be deemed a late cancellation, to be rescheduled and paid in full. Regardless of the length of the treatment actually given, **you will be responsible for the "full" price of your session**. Out of respect and consideration to your therapist and other customers, **please** plan accordingly and be on time.

Cancellation Policy
If you are unable to make your scheduled appointment a **48-hour advance notice is required** when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment. After the first late cancellation or no show, a credit card is needed to rebook future appointments and you will be charged 100% of the full amount of your missed appointment to the credit card provided. When using a prepaid session or Gift Certificate, 100% of the session value will be deducted from your prepaid session(s) when failing to provide **48-hour advance notice**. Please Initial _________

No-shows
Anyone who either forgets or consciously chooses to not show for their appointment for whatever reason will be considered a "no-show." Any person who is deemed a "no-show" will be subject to our **Cancellation Policy** as outlined above.

______________________________ ______________________________
Client Name Printed **Date**

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Client Signature

Summary of our privacy policies:
The office does not and will not disclose ANY information about our clients at any time without expressly written consent unless proper confidential legal representation has been retained. All medical information is strictly confidential and will only be shared with the client's approval for purposes of referrals and in working with your healthcare professional.