

~Client Confidential Intake Form~

Name: _____ Date: _____

Phone: cell (_____) _____ hm (_____) _____ wk (_____) _____

Address: _____ City _____ State _____ Zip _____

D.O.B: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Have you ever received a professional massage? Yes No Can I contact you via text? Yes No

Reason / Goals for today's session: _____

Current Health~

Check any of the following that apply:

Pregnancy Diabetes Heart conditions Circulatory conditions

Infections Arthritis Cancer Difficulty breathing

Blood clots Asthma Osteoporosis Contagious skin condition

Headaches/Migraines Contact lenses Recent accident or injury

Sensitivities to oils/lotion Sensitive skin Allergies

Please explain the condition(s) you have checked: _____

Do you have any OTHER conditions or concerns that I should be aware of before your massage therapy session? _____

Current Medications: _____
(include over-the-counter pain relievers and herbal remedies)

Health History~

Surgeries: _____ Injuries: _____

Major Illnesses: _____

Consent For Care~

I understand that the massage therapy provided here is for the basic purpose of *stress reduction, relief from muscular tension or spasm, increased circulation, increased energy and relief from stiff joints*. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I am aware of the benefits and risks of massage and give my consent for massage. If I experience any pain or discomfort during the session I will immediately inform the therapist so that pressure/strokes may be adjusted to my level of comfort.

I understand that the massage therapist is not qualified to perform spinal or skeletal adjustments, diagnose illness, disease or any other physical or mental condition. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis and should not be construed as such.

Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and answered all questions honestly and agree to inform my practitioner of any changes in my health status. I understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of Client: _____ **Date:** _____

Signature of L.M.T.: _____ **Date:** _____