Massage Therapy New Patient Intake Form

Welcome to our practice! Please help us serve you better by taking a few minutes to provide the following information.

Name_____Cell#_____Home#_____

Address_____ City, State, ZIP_____

Email_____DOB_____ Male____ Female____

Emergency Contact and #_____

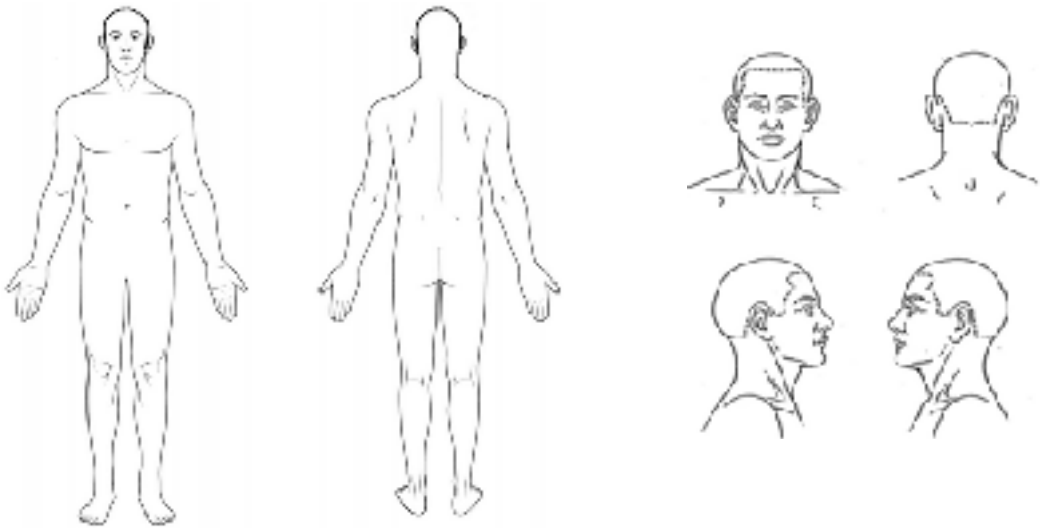
Occupation:_____ Employer:_____

Referred by_____ Allergies_____

What is the primary issue/problem/reason that brings you in today?

_____

Please Indicate any areas of concern.



What are your goals/expectations for this therapy session?_____

_____

Are there any areas you would like me to avoid?_____

Please list all previous surgeries/trauma/falls_____

_____

Please list any Medication you are currently taking_____

_____

(over for page 2)

Do you have a history of the following? Check all that apply:

	Abdominal Pain		Chronic Fatigue Syndrome		Low Back Pain
	Abdominal Surgery		Concussion		Mastectomy
	Accident		Diabetes		Neurological Disorder
	Acne		Diarrhea		Numbness/Tingling
	AIDS/HIV		Dizziness/Fainting		Paralysis
	Any Contagious Illness		Decreased Range of Motion		Plates/Screws
	Arthritis OA/RA		Epilepsy/Seizures		Rash/Shingles
	Asthma		Emphysema		Scoliosis
	Athlete's Foot		Fever		Sinusitis
	Anxiety		Fibromyalgia		Sleeping Issues
	Back Pain		Heart Attack		Stents/Shunts
	Blood Clots		Headaches/Migraines		Spinal Problems
	Bleeding Disorders		Hernia		Stroke
	Broken Bones		Herpes		Sciatica
	Breast Augmentation		High/Low Blood Pressure		Varicose Veins
	Bruises/Cuts/Wounds		Infection		Other:
	Cancer/Tumors		IBS		
	Circulatory Problems		Joint Pain		
	Constipation		Kidney Disease		
	Carpal Tunnel		Liver Disorder		

Provisions of the Massage
During your massage the therapist may use Myofascial Release, Craniosacral Therapy, trigger point, cross fiber, Swedish or other approved techniques to facilitate the massage. The therapist will massage the necessary body parts to facilitate the massage excluding any contraindication areas. The therapist will not work the breast area without consent by the client. Proper draping will be used throughout the whole massage. If at any time the client is uncomfortable with the massage the therapist will discontinue the massage. I have read and understand the questions above and the statements regarding the provisions of the massage. _____(Initial) I consent to work around breast area._____ (Initial if agreed)

Clients Waiver
Massage therapy is not a substitute for medical examinations and diagnosis. It is recommended that I see a physician for any physical ailment that I may have. I understand that the massage therapist does not prescribe medical treatment of pharmaceuticals nor does the therapist perform any spinal adjustments. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all of my know medical conditions that there shall be no liability on the practitioner's part should I fail to do so. _____ (initial)

Payment, Cancelation, and No Show Policy
Payment, in the form of cash, check or credit card, is due at the time of each visit.
Cancelations must be made 24 hours prior to your appointment time. If you do not show up for your appointment or cancel within 24 hours, you will be responsible for 100% of the session. _____(Initial)

Client Signature_____Date_____ Therapist Signature_____Date____

Type of Massage Technique to be implemented: MFR CST Visceral Swedish
Parts of the body to be massaged (including indications and contraindications):_____________
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Client Signature:____Date___________
(Parent or Guardian if under the age of 17)

Therapist Signature:____Date___________

Type of Massage Technique to be implemented: MFR CST Visceral Swedish
Parts of the body to be massaged (including indications and contraindications):_____________
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Client Signature:____Date___________
(Parent or Guardian if under the age of 17)
Therapist Signature:____Date___________

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