Client Intake and Consent

Name: ____________________________________ Date: __________
Date of Birth: ______________ Gender/pronouns: _______________________
Address: ____
Phone:_____________________ Email: ____
Referred by: ______________________________
Emergency contact: ____________________________ Phone: ____________________

Massage Information

Have you ever received professional massage/bodywork before? Yes No
How recently/often? ______________________________
What kind of pressure do you prefer? Light Medium Firm
What are your goals/expected outcomes for receiving massage/bodywork?
____
List and prioritize your current symptoms/issues:
____
____
List the medications you currently take:
____
____
Are you pregnant? Yes No Recently given birth? Yes (when?) ________ No

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. 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 physician or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive advances made by me may result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: ____ Date: __________
Parent Signature (in case of a minor): ________________________ Date: __________

Health History

Do you have any past injuries or surgeries that may influence today's treatment?

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Circle any of the following health conditions that you currently have (If you are unsure, please ask):

blood clots, infections, congestive heart failure, contagious diseases, pitted edema

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current Past Muscle or joint pain ________________________
Current Past Muscle or joint stiffness ________________________
Current Past Numbness or tingling ________________________
Current Past Swelling ________________________
Current Past Bruise easily ________________________
Current Past Sensitive to touch/pressure ________________________
Current Past High/Low blood pressure ________________________
Current Past Stroke, heart attack ________________________
Current Past Varicose veins ________________________
Current Past Shortness of breath, asthma ________________________
Current Past Cancer ________________________
Current Past MS, Parkinson's, chronic pain ________________________
Current Past Epilepsy, seizures ________________________
Current Past Headaches, Migraines ________________________
Current Past Dizziness, ringing in the ears ________________________
Current Past Digestive conditions (e.g. Crohn's, IBS) ________________________
Current Past Gas, bloating, constipation ________________________
Current Past Kidney disease, infection ________________________
Current Past Arthritis (rheumatoid, osteoarthritis) ________________________
Current Past Osteoporosis, degenerative spine/disk ________________________
Current Past Scoliosis ________________________
Current Past Broken bones ________________________
Current Past Allergies ________________________
Current Past Diabetes ________________________
Current Past Endocrine/thyroid conditions ________________________
Current Past Depression, anxiety ________________________
Current Past Memory Loss, confusion, easily overwhelmed ________________________

Additional comments:

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