

MESSAGE INTAKE FORM

WELCOME! We would like to make your appointment as pleasant and comfortable as possible.
If at any time you have questions regarding your session, please let your therapist know.

Date _____ Client Name _____ DOB _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Would you like to receive quarterly email notifications of our online newsletter? No Yes Email Address: _____

Occupation _____ Referred By _____

Emergency Contact _____ Phone _____

Have you ever experienced a professional massage or bodywork session? No Yes How recently? _____

What is your desired pressure? Light Medium Deep Are you wearing: contact lenses hearing aid hairpiece

Are you sensitive to touch in any area? Please list: _____

What is your purpose for seeking massage therapy / bodywork? General Relaxation Stress Management Injury Prevention
 Injury Recovery Pain Management Other _____

Please list any injuries / accidents / surgeries you've had in the past 5 years: _____

Place a check mark next to any of the following that you have now or have had in the past:

Auto-Immune Conditions

- Fibromyalgia
- Chronic Fatigue
- Myofascial Pain Syndrome
- Lupus
- AIDS / HIV

Respiratory

- Breathing difficulty / Asthma
- Emphysema
- Sinus problems
- Chronic or frequent cough
- Allergies (please specify) : _____

Skin

- Rashes
- Athletes foot
- Herpes / cold sore
- Epilepsy
- Allergies (please specify) : _____

Digestive

- Irritable bowel syndrome
- Ulcers

Nervous System

- Shingles
- Numbness / tingling
- Pinched nerve
- Epilepsy

Reproductive

- Pregnant: Stage _____
- Ovarian / menstrual problems
- Prostate

Circulatory

- Anemia
- Heart condition
- Phlebitis / Varicose veins
- Blood clots
- High / Low blood pressure
- Lymphedema
- Thrombosis / Embolism
- Swelling of hands / feet
- Bruise easily
- Light headed or dizziness
- Cold extremities

Musculoskeletal

- Bone or joint disease
- Tendonitis / Bursitis
- Arthritis / Gout
- Jaw pain (TMJ)
- Neck / Back pain:
Neck Mid Back Low Back
- Joint pain, stiffness, swelling
- Joint / muscle weakness
- Muscle cramps or pain

Other

- Cancer / tumors
- Bladder / kidney ailment
- Diabetes
- Chronic pain
- Sleep disorders
- Migraines / headaches
- Anxiety / stress syndrome
- Depression
- Hernia
- Other: _____

Please list any medications you are currently taking for above conditions (include nonprescription) : _____

Cancellation Policy

This office has a policy of charging a fee for missing an appointment or cancelling with less than 24 hours notice. The fee will be 50% of the regular charge for the missed session, regardless of discounts such as value package rates or senior discounts. Obviously, acute health problems and family crises are expected. Cancellations of convenience or last minute schedule conflicts will be your responsibility.

Bad Check Policy

There will be a \$25.00 fee for all checks returned by your bank unpaid due to lack of sufficient funds.

Payment Agreement

I understand that payment in full is due at the time of service unless other arrangements have been made. I understand that any unpaid balances may be subject to an 18% annual interest rate, compounded at 1.5% each month. I agree to be held responsible for all attorney fees and court costs involved with the collection of this account.

Please take a moment to carefully read the following information and sign where indicated

I have read and fully understand the above policies. I agree to abide by the policies as stated.

I have read and discussed the medical information on this form. I understand that this work does not constitute a medical treatment but rather is a form of health promotion. I affirm that I have stated all of my known medical conditions and have answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I understand that massage/bodywork may be contraindicated for specific medical conditions or symptoms. I understand a referral from my primary care provider may be required prior to services being provided. 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 also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client or Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____