mind & matter

Massage Client Intake Form

Name: _____ Date: _____
Street Address: _____ Phone Number: _____
City, State, Zip: _____ Mobile? Y | N Text? Y | N
Email: _____ Date of Birth: _____
Occupation: _____ Age: _____
Referred By: _____

In Case of Emergency:
Emergency Contact: _____ *Relationship:* _____
Contact Number: _____

Please take a moment to carefully read the following information and sign where indicated. Certain medical conditions or symptoms may be contraindicated and may result in either an inability to perform the massage or may require a referral from a physician.

Are you, or is there any chance you may be pregnant? **Y | N** If yes, how far along? _____

Do you have any sensitivities to oils, lotions, or fragrances? **Y | N**

Have you ever experienced a professional massage? **Y | N** If so, how recently? _____

Do you have a preferred pressure? *(If unsure or don't know, leave blank)*
Light/Meditative | Heavy/Invigorating | Deep/Trigger Point

Please indicate if you currently have or have ever had any of the following:

- ☐ Allergies/Sensitivities
- ☐ Arthritis/Tendonitis
- ☐ Autoimmune Disease
- ☐ Back Pain
- ☐ Blood Clots
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Congestive Heart Failure
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Headaches/Migraines
- ☐ Heart/Circulation Problems
- ☐ Hemophilia
- ☐ High/Low Blood Pressure
- ☐ HIV/AIDS
- ☐ Joint Dysplasia
- ☐ Joint Replacement
- ☐ Leg/Knee Pain
- ☐ Neck Pain
- ☐ Numbness/Tingling
- ☐ Osteoporosis/Osteopenia
- ☐ Recent Trauma/Injury
- ☐ Seizures
- ☐ Skin Condition(s)
- ☐ Sprain/Strain
- ☐ Thrombophlebitis/Deep Vein Thrombosis
- ☐ TMJ Dysfunction
- ☐ Varicose Veins
- ☐ Any other conditions not listed you would like your therapist to know about:

_____
_____
_____
_____

What is your reason for today's visit? _____
_____

Any other major complaints or concerns? _____
_____

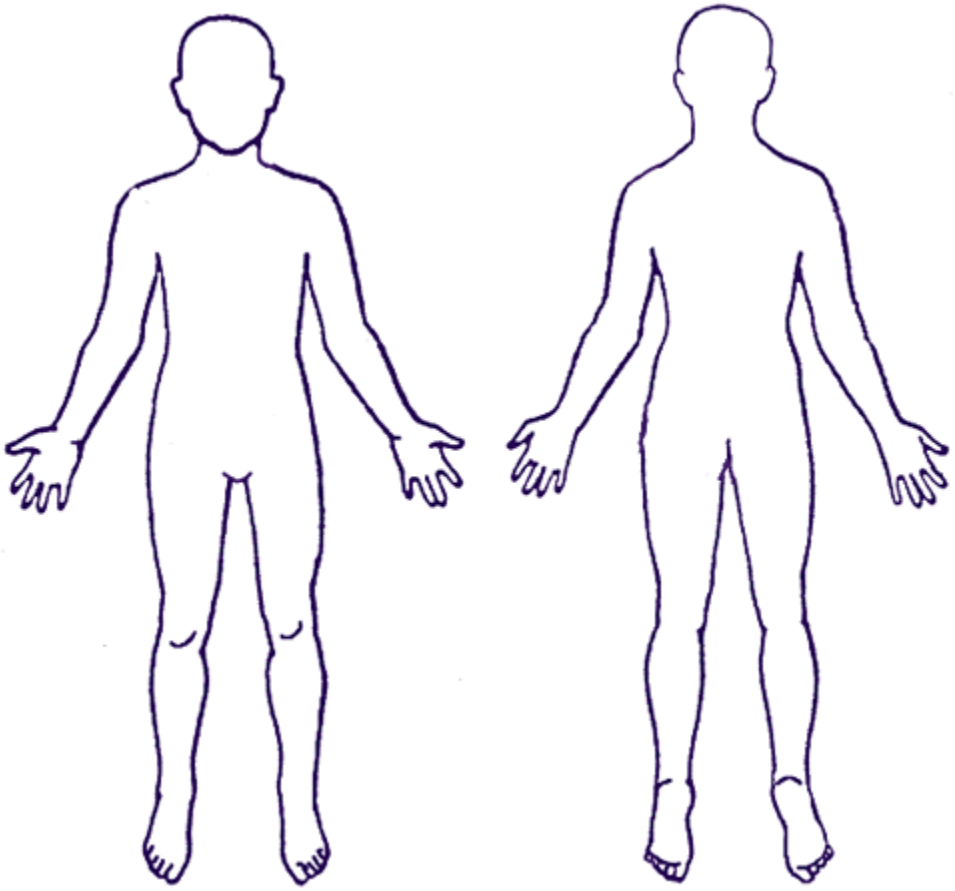
Please indicate if you are currently experiencing any of the following:

- ☐ Cold or Flu
- ☐ Fever
- ☐ Headache
- ☐ Inflammation
- ☐ Irritated Skin/Rash
- ☐ Cuts or Burns
- ☐ Open Wound/ Sore Severe Pain
- ☐ Sunburn

Are you currently on blood thinners? **Y | N** Are you currently on any blood pressure medication? **Y | N**

Please list any current prescribed medications you may be taking? _____
_____

PLEASE INDICATE BELOW AREAS OF PAIN/DISCOMFORT WITH AN 'X':



Massage Therapy Client Informed Consent

(PLEASE INITIAL AFTER EACH POINT)

I understand that the massage therapy given here is for stress reduction, relief from muscular tension or spasm, or for increasing circulation and energy flow. _____

I understand that massage therapy is a therapeutic health aid and is non-sexual. I also understand that any illicit or sexually suggestive remarks or advances made by my will result in immediate termination of the session, and I will be liable for full payment of the scheduled appointment. _____

I have informed the massage therapist of all my known physical conditions, medical conditions, and medications, and I will keep the massage therapist updated on any changes. I understand that certain medical conditions are contraindicated in massage and assure that I have not withheld any such conditions from my therapist, and I understand that there shall be no liability on the practitioner's part due to my failure to relay any pertinent information. _____

I understand massage is designed to be a health aid and is in no way to take the place of a doctor's care when a doctor's care is indicated. Massage therapy is not in place of physician care. _____

I understand that a massage therapist does not diagnose illness, disease, nor any other physical or mental disorder. I understand that a massage therapist does not prescribe medical treatment or pharmaceuticals or perform any spinal/joint manipulations. It has been made clear to me that massage therapy is not a substitute for medical examinations and/or diagnoses and that it is recommended that I see a physician for any physical ailment(s) that I might have. _____

Client Name (please print): _____

Client Signature: _____ Date: _____

MISSED APPOINTMENT AND CENCELLATION POLICY (as of March 1st, 2018)

If you are unable to keep your scheduled appointment, please notify your therapist no later than ***8:00pm the day prior to your appointment****.*

If notice is given after 8:0pm on the previous day and we are unable to fill your time slot, clients will be responsible for a ***cancellation fee of 20% of the total scheduled service cost.***

For any appointments that are a no-call/no-show, you will be expected to pay for the ***full cost of the scheduled appointment****.*

Exceptions for emergencies, weather, etc. will be given on a case-by-case basis.

_____

Client Initials