Mobile Massage and Fitness

In-Home Massage Therapy and Personal Training

Client Intake Form – Therapeutic Massage

Personal Information:

Name: _____

Date:_____

Home Phone: _____ Cell Phone: _____

Address: _____

City/State/Zip: _____

Email: _____

Date of Birth: _____

Occupation: _____

Emergency Contact Name and Phone:

_____

The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge

1. Have you had a professional massage before? Yes/No
If yes, how often do you receive massage therapy?
2. Do you have any difficulty lying on your front, back, or side? Yes/No
If yes, please explain:

_____

3. Do you have any allergies to oils, lotions, or ointments? Yes/ No
If yes, please explain:

_____

4. Do you have sensitive skin? Yes/ No
5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( )?
6. Do you sit for long hours at a workstation, computer, or driving? Yes/ No
If yes, please describe:

_____

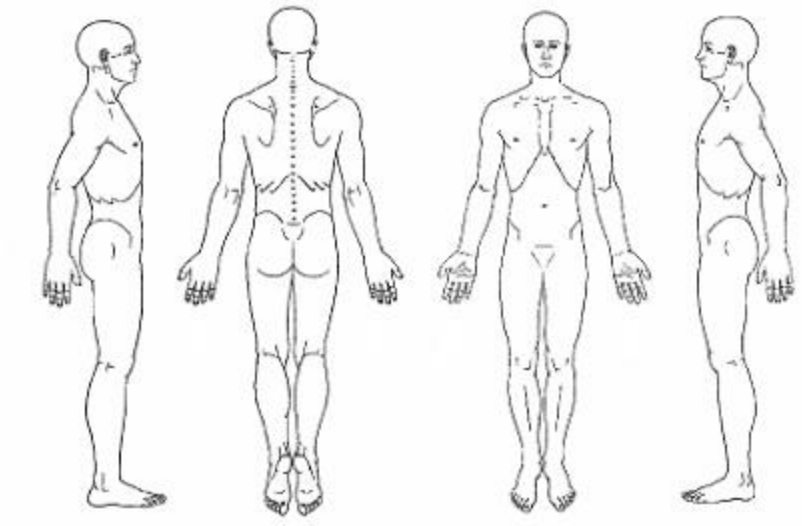
7. Do you perform any repetitive movement in your work, sports, or hobby? Yes/ No
If yes, please describe:

_____

8. Do you experience stress in your work, family, or other aspect of your life? Yes/ No
If yes, how do you think it has affected your health?

Muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other ( )

9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?
Yes /No
If yes, please identify below.
Circle any specific areas you would like the massage therapist to concentrate on during the session:



10. Do you have any particular goals in mind for this massage session? Yes/ No
If yes, please explain:

Medical History In order to plan a massage session that is safe and effective, I need some general information about your medical history.

( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) Fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) pregnancy If yes, how many months?

11. Are you currently under medical supervision? Yes/No
If yes, please explain:

_____

12. Do you see a chiropractor? Yes/No If yes, how often? _____

13. Are you currently taking any medication? Yes/ No
If yes, please list:

_____

14. Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis

Please explain any condition that you have marked above:

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15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

Draping will be used during the session – only the area being worked on will be uncovered.
Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, (print name) _____ understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists 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 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 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.

Signature of client:

_____

Date: _____

Signature of Massage Therapist:

_____

Date: _____

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www.mobilemassageandfitness.com

(206)579-7960

24 Hour Appointment Cancellation Policy

Mobile Massage Therapy and Fitness, LLC has a 24 hour cancellation / rescheduling policy.
A $45 charge will apply if you miss your appointment or cancel or change your appointment with less than 24 hours' notice.
This policy is in place out of respect for our therapists and our clients. Cancellations with less than 24 hour notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.
By signing below, you acknowledge that you have read and understand the Cancellation Policy for Mobile Massage Therapy and Fitness, LLC as described above.
Thank you for your understanding and cooperation.

_____

Printed name

_____

Signature

_____

Date