ACUPUNCTURE & WELLNESS CENTER

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M04387

Massage Intake Form

The goal of your massage therapist is to provide you with a comfortable and pleasant experience. Please assist your massage therapist in meeting that goal by providing the information requested below.

Name: _____ Date: _____

Address: _____ Home Phone: _____

City, State, Zip: _____ Cell Phone: _____

Email Address: _____ Date of Birth: ____/____/____

Occupation: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Telephone #: _____

Referred By: _____

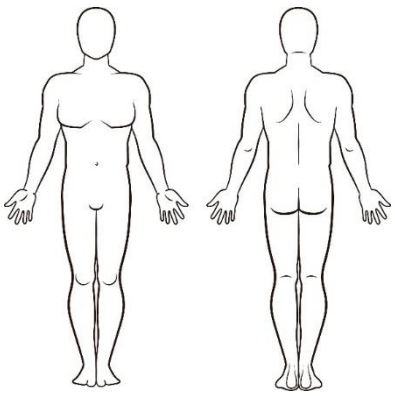
On a scale from one to ten, with ten being the worst, what is your pain or discomfort level? _____

Please describe any tightness, tension, or pain that you may be feeling _____

_____

Have you seen a physician for this discomfort? _____

_____



Have you had a professional massage before? Yes No

What type of massage are you seeking? Relaxation Therapeutic/deep tissue

Other _____

What pressure do you prefer? Light Medium Deep

Are you sensitive or allergic to any essential oils, lotions, scents, etc.? Yes No

If yes, please explain: _____

Are there any areas (eg. abdomen, face, feet, etc.) you do not want to be massaged? Yes No

If yes, please explain: _____

What are your goals for this treatment session? _____

_____

Please list any medications you are currently taking and reasons: _____

_____

Please list any surgeries you have had (types and dates): _____

_____

Are you currently pregnant? Yes No How far along? _____ Any high risk factors? _____

Do you suffer from chronic pain? Yes No If yes, please explain _____

_____

What makes it better? _____ What makes it worse? _____

Have you had any orthopedic injuries? Yes No If yes, please list: _____

_____

Please indicate any of the following that apply to you:

❑Abdominal Pain ❑Arthritis ❑Asthma ❑Athlete's Foot ❑Blood Clots ❑Cancer

❑Diabetes ❑Ehlers-Danlos Syndrome ❑Fibromyalgia ❑Headaches ❑Heart Condition

❑Hemophilia ❑High/Low Blood Pressure ❑HIV/ Aids ❑Joint Replacement ❑Kidney Disfunction

❑Migraines ❑Numbness/Tingling ❑Neuropathy ❑Sciatica ❑Scoliosis ❑Seizures

❑Skin Conditions ❑Sprains/Strains ❑Stroke ❑Transplant Recipient ❑Varicose Veins

❑Von Willebrand Disease ❑Other _____

Are you taking blood thinners? _____

Explain any conditions you have marked above: _____

_____

By signing below, you agree to the following:

I agree that I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ Date _____

Consent to Treatment – Please read and sign below:

I understand that massage/bodywork 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 of which I am aware. 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 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 understand the risks associated with massage therapy include but are not limited to:

- Superficial Bruising
- Short-term muscle soreness
- Exacerbation of undiscovered injury

I understand that I or the massage therapist may terminate the session at any time.

I have been given a chance to ask questions about the massage therapy session and my questions have been answered. Understanding all of this, I give my consent to receive care.

_____

Print Client Name

_____ _____

Client's Signature Date