Massage Client Intake Form

Personal information (please print)

Name: _____H Phone _____C Phone: _____Texting Y or N

Address/City/State/Zip: _____DOB _____

Occupation_____ Employer_____

Email _____Primary Physician _____

Emergency Contact: _____Relationship _____Phone_____

How did you hear about me?_____

Medical Information

Are you taking any medications? Y N
If yes, please list name and use:_____
_____
_____

Are you currently pregnant? Y N
If yes, how far along?_____
Any high risk factors?_____

Do you suffer from chronic pain Y N
If yes, please explain _____
What makes it better?_____
_____
What makes it worse?_____

Please indicate any condition you have or had recently

Arthritis	Cancer
Headaches/Migraines	Joint Replacement (s)
Tendonitis	Stroke
Fibromyalgia	Heart Attack
Varicose veins	Sprains/Strains
Blood clots	High/low blood pressure
Diabetes	Clench/grind teeth/TMJD
Numbness	Circulation problems

Do you have any allergies or sensitivities? Y N

List and date any surgeries, injuries, accidents, breaks, falls: __
_____
_____
_____
_____

By signing below, you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the about information changes at any time.

Patients Signature _____

Date_____

Massage Information

What type of massage are you seeking today?

Relaxation Deep Tissue Medical Specific Areas

What pressure do you prefer? Light Medium Deep

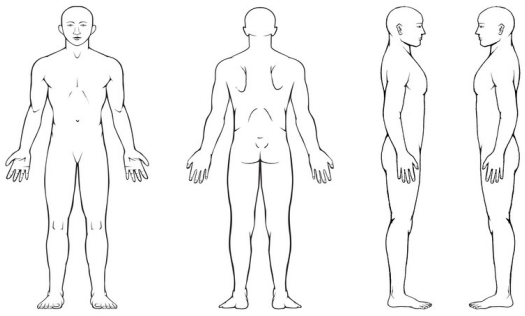
Indicate pain level from 1 (low) to 10(high) on the line provided.

Head	_____	Hips/Glutes	_____
Neck	_____	Legs	_____
Shoulders	_____	Knees	_____
Arms	_____	Ankle/Feet	_____
Back	_____		

Have you received other treatment for this condition? **Y** or **N:** describe
_____
Name of Physician treated by _____

Are there any areas (feet, face, head, abdomen, etc.) you do not want massaged? Y_____ N

Please circle any areas of discomfort



Describe your condition _____
_____
_____
_____
_____

I understand that the massage given to me by Cindy Hebert is for the purpose of (stress reduction, pain reduction, relief from muscle tension, increasing circulation, or specific reasons stated here).

I understand that the massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.

I understand that massage therapy is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have.

I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes.

Client signature _____ date _____

Cancellation and No Show Policy

I understand that situations arise in which you must cancel your appointment. If you are unable to keep a scheduled appointment, please give 24 hours advance notice. This will give me time to fill the slot for someone else who may need the appointment. If less than 24 hour notice is given and I am unable to fill the slot, you may be charged 50% of your scheduled service for the first time and 100% for any late cancelations after.

No Shows will be handled the same way.

The charge will be added to your credit card on file or paid at the time of your next visit.

I sincerely thank you for your understanding.