



MESSAGE CLIENT INTAKE

(All information is kept strictly confidential)

Name _____ Home Phone (_____) _____ Leave Message Yes No

Address _____ Cell Phone (_____) _____ Leave Message Yes No

E-mail: _____ Birth Date: _____

Emergency Contact: _____ Phone: (_____) _____

Whom may we thank for your referral? _____

Please take a moment to read the following information. If you have a specific condition or symptoms, bodywork or hypnotherapy may be contraindicated. We may request a referral from your primary care physician prior to service being provided.

Are you currently under a doctor's care? Yes No If yes, please explain _____

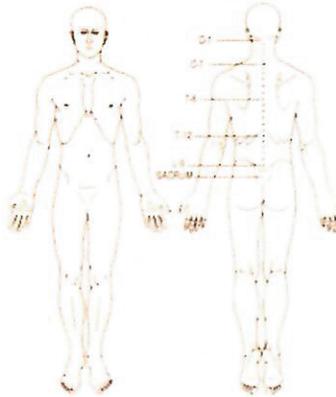
List current medications, medicinal herbs and/or supplements: _____

Have you ever received a professional massage? Yes No How recently? _____ What kind? _____

What type of pressure do you prefer? light medium firm

Have you had any injuries in the past 72 hours? Yes No Explain _____

Please mark below any areas of pain or discomfort:



Please check the appropriate boxes for all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from stress | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have diabetes? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No Any broken bones in the past two yrs? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience frequent headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No Any injuries in the past two years? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing contact lenses? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a cardiac or circulatory problem? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing dentures? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from back pain? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have numbness or stabbing pain? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking blood pressure medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have pacemaker? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from epilepsy or seizure? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have osteoporosis? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have asthma? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have allergies? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have arthritis? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any contagious diseases? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have varicose veins? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you bruise easily? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you or have you been treated for cancer? | |

I understand that the massage I receive is provided for the purpose of relaxation, relief of muscular tension, spasms or pain. It is my choice to receive the massage. If I experience any discomfort during a session I will communicate with the practitioner immediately so that my level of comfort will be adjusted. I further understand that massage is not a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medial specialist for any medial or physical ailment for which I am aware. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness and nothing said in the course of a session given should be construed as the practitioner updated as to any changes to my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexual suggestive remarks or advances by me will result in immediate termination of the session and I will be liable for the session payment

Client Signature _____ Date _____