Rise 2 Health

Client Intake Form - Massage

Personal Information: Date:_____

Name _____ Phone (Day) _____ Phone (Eve) _____

What do you like to be called? _____ Preferred Pronoun _____

Address _____

City/State/Zip _____

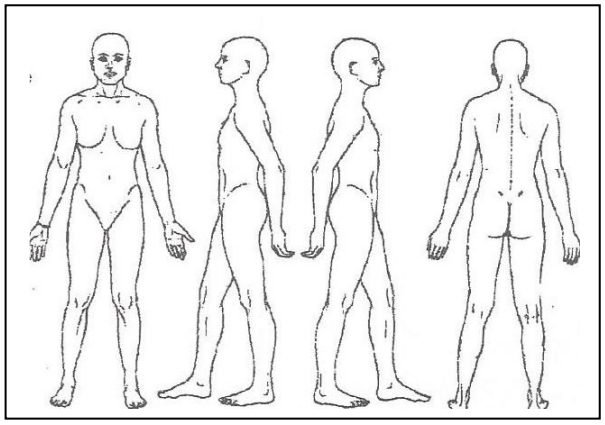
Email _____ Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

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

1. Have you had a professional massage before? Yes No If yes, how often? _____
2. Do you have any difficulty lying on your front, back or side? Yes No
   If yes, please explain. _____
3. Do you have any food allergies or 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 have any particular goals in mind for this massage session? Yes No
   If yes, please explain. _____
7. For therapeutic massage clients, what kind of pressure do you prefer? Light Medium Deep
8. Do you like conversation during your massage? _____

Circle any specific areas you would like the massage therapist to concentrate on during your session.



Medical History

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

9. Are you currently under medical supervision? Yes No
   If yes, please explain. _____

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

( ) contagious skin condition
( ) open sores or wounds
( ) recent accident or injury
( ) recent surgery
( ) artificial joint
( ) current fever
( ) back/neck problems
( ) heart condition
( ) carpal tunnel syndrome
( ) varicose veins
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) osteoporosis
( ) headaches/migraines
( ) sprains/strains
( ) decreased sensation
( ) allergies/sensitivity
( ) TMJ
( ) circulatory disorder
( ) atherosclerosis
( ) easy bruising
( ) epilepsy
( ) recent fracture
( ) cancer
( ) diabetes
( ) swollen glands
( ) fibromyalgia
( ) high or low blood pressure
( ) tennis elbow
( ) pregnancy If yes, no. of months _____
( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis

Please explain any condition that you have marked above. _____

_____

11. If there is 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, please let me know. _____

_____

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 the course of the session 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 provide 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 _____