MASSAGE THERAPY

CLIENT INTAKE FORM

CLIENT INFORMATION

Name: _____ Date: _____

Occupation: _____ D.O.B: _____ ☐ Female ☐ Male ☐ NB

Address: _____

City: _____ State: _____ Postcode: _____

Phone: _____ Email: _____

Emergency contact: _____ Phone #: _____

Would you like to discuss other herbal products such as infused oils to support your well being? *Yes* ☐ *No* ☐

MEDICAL HISTORY *Do you have or have you had any of the following conditions? If yes, please select them:*

- ☐ Arthritis / joint disorder
- ☐ Artificial joint
- ☐ Atherosclerosis
- ☐ Blood disorder
- ☐ Back/neck problems
- ☐ Cancer
- ☐ Carpal tunnel syndrome
- ☐ Circulatory disorder
- ☐ Contagious skin condition
- ☐ Decreased sensation
- ☐ Deep vein thrombosis
- ☐ Diabetes
- ☐ Easy bruising
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Fibromyalgia
- ☐ Headaches/migraines
- ☐ Heart condition
- ☐ High/low blood pressure
- ☐ Immune disorders
- ☐ Keloid scarring
- ☐ Open sores or wounds
- ☐ Osteoporosis
- ☐ Phlebitis
- ☐ Pregnant
- ☐ Recent accident/injury
- ☐ Recent fracture
- ☐ Seborrhea
- ☐ Seizure disorder
- ☐ Skin disease/lesions
- ☐ Sprains/strains
- ☐ Swollen glands
- ☐ Tennis elbow
- ☐ TMJ
- ☐ Varicose veins

Other medical conditions, surgeries or injuries not listed (past and present):

_____

_____

Current medications (including aspirin, ibuprofen, herbs, vitamins, etc):

_____

M A S S A G E T H E R A P Y

CLIENT INTAKE FORM

MASSAGE INFORMATION

Have you had a professional massage before? ☐ Yes ☐ No

What are your current complaints and injuries? _____

_____

Which of the following best describes what you are experiencing?

- ☐ Pain
- ☐ Ache
- ☐ Tension
- ☐ Discomfort
- ☐ Imbalance

- ☐ Mild
- ☐ Moderate
- ☐ Disabling
- ☐ Constant
- ☐ Intermittent

- ☐ Getting worse
- ☐ Staying the same
- ☐ Getting better
- ☐ Increase with activity
- ☐ Reduces with activity

- ☐ Other information _____

List any activities that are limited by your current condition i.e. work, sport, sleep etc.:

_____

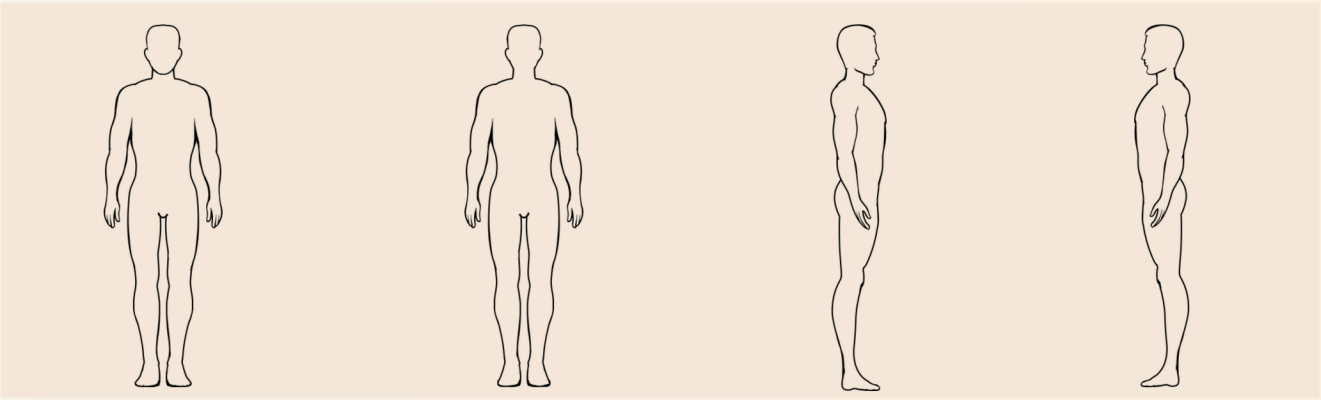
_____

List your self care activities i.e. stretching, exercise and ways to reduce stress:

_____

_____

On the diagram below indicate where your current symptoms are by circling the area:



*By signing below, I hereby acknowledge and agree the information I have provided to be true and correct. I consent to my therapist touching areas relating to my treatment and will advise of any areas that are not to be touched. I understand that all answers and statements contained in this personal record, will be kept confidential and only shared with those involved with my treatment. To properly treat you, the massage therapist must be aware of all past and present physical conditions, I have stated all my medical conditions and take it upon myself to keep the massage therapist updated on my physical health during any treatments.

_____	_____	_____
Client Name (printed)	*Client Name (signature)*	*Date*

MASSAGE THERAPY

CONSENT FORM

Client Legal Name:

SCOPE OF PRACTICE Massage therapy is a profession in which the practitioner applies manual techniques, and may apply adjunctive therapies, with the intention of positively affecting the health and well-being of the client.
Massage Therapists do not diagnose or prescribe for medical conditions nor are they allowed to provide treatment for a specific condition without a doctor's supervision. The massage therapist is required to refer you for diagnosis and to follow recommendations of your physician. The massage therapist are happy to adjust pressure, temperature, music volume, work longer on an area or move on if you request it.

MEDICAL CONDITIONS

It is the responsibility of the client to keep the massage therapist informed of any medical treatment currently being taken, and to provide written permission from the physician, chiropractor, physical therapist, etc., that the massage may be continued. The client must also keep the massage therapist informed of any changes in health conditions.

CONSENT

Please initial to acknowledge that you have been informed of the following:

☐ I understand that if I experience any pain or discomfort during the 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 Therapy 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.

☐ Massage should not be performed under certain medical conditions and I affirm that I have stated all my known medical conditions, and answered all questions honestly.

Client Initials: ☐

MASSAGE THERAPY

CONSENT FORM

- [ ] I will keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist should I fail to do so.
- [ ] This is a Therapeutic Massage session, and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
- [ ] I understand the Massage Therapist practitioner reserves the right to refuse services for any reason that she deems necessary.
- [ ] I understand that I must ensure I present in a clean (freshly showered) and hygienic manner for treatment, ensuring any broken or irritated skin is covered and advise my practitioner on arrival of any massage contraindications including, without limitation, broken or irritated skin so that the area/s can be avoided.
- [ ] I understand that the table used during treatment has a working weight capacity of 204kgms (including weight of client + force of therapist) and although is designed to provide safe and support weight within it's limit, that any risks associated with exceeding its limit are the responsibility of the client.

****Please note that if the safe practices standards above are not met, your therapist will be unable to provide a massage treatment. We appreciate clients for attending to the required standards, which are part of the professional service provided by B Revitalized.

My signature acknowledges that I have read and agree to receive the massage therapy and that I will adhere to all of the aforementioned statements that I have initialed.

Client Name (printed)	*Client Name (signature)*	*Date*