Client Intake Form

Name____ Date of Birth______/______/__________

Address____ Apt/Unit__________________

City____ State________ Zip_______________

Home Phone_____________________ Work_____________________ Cell________________________

Email____ Occupation__________________________

Emergency Contact Name__________________________________ Phone_______________________

How did you hear about us? ____

What would you like to achieve from massage therapy? (Check all that apply)

☐ Stress Reduction ☐ Pain Reduction/Management ☐ Increased Mobility/Flexibility

☐ Relaxation ☐ Other ____

Have you ever received a professional massage? ☐ No ☐ Yes, When? ____________________________

Do you have tension or soreness in any specific areas? ☐ No ☐ Yes, Where? _______________________

____

HEALTH AND MEDICAL INFORMATION

Have you been in an accident or suffered any injuries in the past 2 years? ☐ No ☐ Yes
If YES, Date of accident and brief description: ____

____

(If you are seeking treatment recently after an accident please make it known to your Therapist, as you may need to fill out a separate form to turn into Insurance or Lawyers.)

Do you bruise easily? ☐ No ☐ Yes (If at any time the pressure during your session is too much, please inform your therapist.)

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:

☐ Diabetes ☐ High Blood Pressure ☐ Varicose Veins ☐ Contagious Diseases ☐ Osteoporosis

☐ Cardiac or Circulatory Problems ☐ Any Broken Bones in the past 2 years

☐ Sensitivities to Touch or Pressure in any specific areas? If checked please explain, _______________

____

☐ Numbness or Stabbing Pains Anywhere? If checked please explain, ___________________________

____

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:

☐ Stress ☐ Frequent Headaches ☐ Arthritis ☐ Epilepsy or Seizures ☐ Joint Swelling ☐ Back Pain

PLEASE CHECK IF YOU ARE WEARING:

☐ Contact Lenses ☐ Dentures

Do you have any sensitivity or allergies to oils or essential oils? ☐ No ☐ Yes, please explain, ____________

____

If you have any other medical condition or are taking any medications I should know about please list, _______

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FEMALE CLIENTS ONLY

Are you pregnant? ☐ No ☐ Yes, when is your due date? ______________________________

Is this your first pregnancy? ☐ No ☐ Yes

Have you ever received massage during pregnancy? ☐ No ☐ Yes

Massage Therapy Waiver and Consent

I understand that the massage/bodywork 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 practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or 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. 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 truthfully. 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 also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, that no further sessions will be allowed to be scheduled, and I will be liable for payment of the scheduled appointment.

Client/Parent/Guardian Signature______________________________________ Date____/_____/_______

Practitioner Signature____ Date____/_____/_______

CONSENT TO TREATMENT OF MINOR

By my signature above, I hereby authorize Erika Nielsen, LMT to administer massage, bodywork, or somatic therapy techniques to my child or dependent as she deems necessary. Initial Here________