Sunflower Lane

Therapeutic Massage
203 Hummingbird Road
Morrisdale, PA 16858
(814) 577-8665

Confidential Client Intake Form

Name _____ **Birthdate** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Phone (H) _____ **Phone (W)**_____ **Phone (C)**_____

E-mail: _____ **Occupation** _____ **Male** __ **Female** __

In case of emergency: _____ **Phone ( )**_____

Primary Care Provider_____ **Permission to consult with PCP? Yes** _____ **No** ___
(Please initial)

Are you seeing a chiropractor? Yes __ **No** __ **Who?** _____ **Referred by?** _____

Have you ever received a professional massage or bodywork? Yes ___ **No** ___ **If yes, how recently?** _____

What results do you want from your massage/bodywork sessions? _____

In order to maximize the effectiveness and safety of our sessions, please take a moment to carefully read and complete the following information and sign where indicated. If you have a specific medical condition or specific symptoms, certain types of massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

If you answer "yes" to any of the following questions, please explain as clearly as possible in the comments.

☐ Yes ☐ No Do you frequently suffer from stress?
☐ Yes ☐ No Do you have diabetes?
☐ Yes ☐ No Do you have asthma?
☐ Yes ☐ No Do you have or ever been treated for cancer/tumors?
☐ Yes ☐ No Do you suffer from arthritis?
☐ Yes ☐ No Do you have osteoporosis?
☐ Yes ☐ No Do you suffer from joint swelling?
☐ Yes ☐ No Do you suffer from fibromyalgia/muscle pain/spasms?
☐ Yes ☐ No Do you bruise easily?
☐ Yes ☐ No Do you have numbness or stabbing pains?
☐ Yes ☐ No Do you suffer from back pain, spinal or disc problems?
☐ Yes ☐ No Do you have cardiac or circulatory problems?
☐ Yes ☐ No Have you ever had a stroke?
☐ Yes ☐ No Do you have high or low blood pressure?
☐ Yes ☐ No Are you taking high blood pressure medication?
☐ Yes ☐ No Do you have varicose veins?
☐ Yes ☐ No Do you suffer from epilepsy or seizures?
☐ Yes ☐ No Any injuries in the past two years?
☐ Yes ☐ No Any broken bones in the past two years?
☐ Yes ☐ No Have you ever had whiplash?
☐ Yes ☐ No Do you experience frequent headaches?
☐ Yes ☐ No Have you ever had surgery? Explain below
_____

☐ Yes ☐ No Are you sensitive to touch/pressure in any area?
☐ Yes ☐ No Do you have any contagious diseases or skin problems?
☐ Yes ☐ No Are you wearing contact lenses?
☐ Yes ☐ No Are you wearing dentures?
☐ Yes ☐ No Are you pregnant? How many weeks? _____
Comments/Questions?_____
☐ Yes ☐ No Do you have tension/soreness in a specific area?
Please specify _____
☐ Yes ☐ No Do you have any allergies? _____
☐ Yes ☐ No Other medical condition, or are you taking any medications I should know about?_____
_____
_____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension or spasm, or for increased circulation and energy flow. 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 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 honestly. 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, and I will be liable for payment of the scheduled appointment.

Client Signature _____ Date _____ Therapist _____ Date _____