MASSAGE CLIENT INTAKE FORM

Personal Data

Today's Date: _____ Date of Birth: _____/_____/_____
mm dd yr

Name: _____ **Home Phone**:_____

E-mail:_____ Cell Phone #_____

Mailing address:_____

City, Province, Postal Code:_____

Occupation:_____ Business phone:_____

Whom may we thank for your referral?_____

HEALTH DATA

Reason for initial visit: _____

Serious illnesses, injuries, or surgeries: _____

Medications:_____

Name of Family physician:_____

Emergency Contact: _____ Phone: _____

Do you wear contact Lenses _____

Please check spaces below for any conditions that you are experiencing or have experienced and inform the Massage Therapist about any changes in your condition immediately (before, during and after treatment)

Soft tissue/joints
___ Tendonitis/bursitis
___ weakness_____
___ sprains/strains
___ Arthritis OA/RA/other
___ herniated disc

Headaches
___ tension
___ migraines
___ tooth/ jaw/ear pain
___ head trauma Date_____

Accident/injury
__ car accident
__ whiplash
Date_____

Symptoms:_____

Physical limitations
_____
_____

__ fractures

Women
___ Pregnant/ due date____
___ gynecological conditions

Respiratory
__ sinus problems
__ chronic cough
__ shortness of breath
__ bronchitis
__ asthma
__ pneumonia

Cardiovascular
__ angina
__ chronic congestive heart failure
__ high blood pressure
__ low blood pressure
__ heart attack
__ phlebitis
__ stroke / CVA
__ pacemaker
__ heart disease

Infectious Disease
__ Hepatitis A /B / C
__ tuberculosis
__ HIV / AIDS
__ Other_____

Skin
__bruise easy
__ herpes
__ varicose veins
__ athletes foot
__ warts/ plantar warts
__ loss of sensation

Other Conditions
__ emphysema
__ neurological conditions
__ epilepsy
__ diabetes
__ allergies
specify_____
anaphylaxis Y / N
__ cancer_____
__ vision problems
__ hearing loss or tinitis
__ constipation
__ other digestive conditions
__ fibromyalgia
__ Insomnia/poor sleeping
__ Kidney / bladder problems
__ hemophilia
__ osteoporosis
__ surgical implants_____

INFORMED CONSENT

PLEASE TAKE A MOMENT TO CAREFULLY READ THE FOLLOWING AND SIGN WHERE INDICATED

The above information is accurate to the best of my knowledge and I freely give my permission to be massaged. Since massage is contraindicated for some serious medical conditions, it may be necessary to obtain a doctor's release or prescription before beginning massage. I understand that massage therapy should not be construed as a substitute for medical examination, diagnosis, and treatments and that I should see a medical or chiropractic doctor or other healthcare specialist. I agree to update the massage therapist in regard to changes in my health and understand that there shall be no liability on the therapist's should I forget to do so.

I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there are risks involved with massage therapy, including but not limited to: muscle tenderness, stiffness, and sometimes slight bruising which has been explained to me and I assume those risks. I do not expect the therapist to be able to anticipate and explain all of the risks and complications associated with massage. I wish to rely on the practitioner to exercise judgement during the course of my treatment(s) based on the facts known.

I understand that:

- The relationship between the client and massage therapist is a confidential one and that all information provided to the therapist is to be kept confidential. However I authorize my Therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party billing companies.
- My body will be properly draped at all times for comfort, security and warmth
- The massage is solely for the purpose of therapeutic massage and that the massage therapist also has the right to be free from any unwanted, harmful, offensive, and /or physical contact or behaviour. This will result in a termination of the session and I will be responsible to pay for the entire session.
- I will inform the therapist of an discomfort, so that the application of pressure or stroke may be adjusted to my level of comfort
- Should I have to cancel the appointment for any reason, I agree to give the therapist a 24 hour notice or I will be billed 50% of the cost of the appointment missed.
- By signing this form, I give consent for future sessions. I have read this form and hereby freely give my permission to be massaged.
- I understand that at any time I may withdraw my consent and treatment will be stopped.
- Fees are due at time of service.

Client Signature_____ Date_____

Consent to treatment of minor—by my signature, I hereby authorize my child or dependant to have massage treatments administered

Signature of parent/guardian_____ Date:_____