THERAPEUTIC MASSAGE - CLIENT INTAKE FORM

87 Bridge Street West,
Bancroft, ON K0L 1C0

416 837-0031
troymillerrmt@gmail.com

Name _____

Phone Number _____

Email _____ Address _____ Date of Birth _____

Emergency Contact _____ City _____ Occupation _____

Phone _____ Province _____ Postal Code _____

MASSAGE INFORMATION

Have you had a professional massage before? Y ❑ N ❑

If yes, how often do you receive therapy? _____

Do you have a style or pressure preference? Y ❑ N ❑

❑ Light Pressure ❑ Medium Pressure ❑ Deep Pressure

❑ Trigger Point Therapy ❑ Energy Work ❑ Other

What type of massage therapy are you seeking today?

❑ Relaxation ❑ Deep Tissue / Therapeutic ❑ Pregnancy

❑ Other _____

Are you sensitive to fragrances or scents? Y ❑ N ❑

Do you have sensitive skin? Y ❑ N ❑

Do you wear contact lenses? Y ❑ N ❑

Do you exercise regularly? Y ❑ N ❑

If so, what type(s)? _____

MEDICAL HISTORY

Please indicate any conditions that you have had or currently have:

❑ Headaches / Migraines
❑ Allergies / Sensitivity
❑ Arthritis / Tendonitis
❑ Cancer / Tumours
❑ TMJ Issues
❑ Abnormal Skin Condition
❑ Heart / Circulation Problems
❑ Joint Replacement / Surgery
❑ High / Low Blood Pressure
❑ Major Accident
❑ Varicose Veins
❑ Pregnancy
❑ Blood Clots
❑ Neck / Back Injuries
❑ Diabetes
❑ Paralysis
❑ Fibromyalgia
❑ Numbness
❑ Sprains / Strains
❑ Recent Injuries

Explain any conditions that you have marked above:

_____

MEDICAL HISTORY

Do you suffer from chronic pain or discomfort? Y ❑ N ❑

If so, how long? _____

Do you know what caused it or when the symptoms seem to get worse or better?

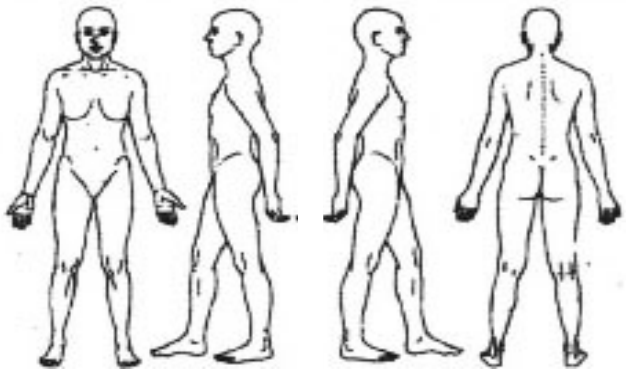
_____

Do you see a chiropractor? Y ❑ N ❑ If so, how often _____

Are you currently under medical care? Y ❑ N ❑

Are you currently taking any prescription medication? Y ❑ N ❑

If so what for? _____



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

AUTHORIZATION: To the best of my knowledge, the above information is complete and accurate. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that i may have made in the completion of this form. I understand that it is my responsibility to inform my health care provider if I ever have a change in health. I understand that massage therapy services are for the primary purpose of short-term relaxation and the relief of muscular tension. I understand that massage therapy services are in no way a substitute for examination, diagnosis or treatment by a physician. I acknowledge that any information I receive from individuals performing massage therapy is educational in nature and is to be used at my own discretion.

Please understand that there is a 24 hour cancellation fee in effect and that a missed appointment fee of $40 will be applied if no conatct has been made to the therapist. Your missed appointment affects the therapists time and bottom-line.

Signature _____ Date _____