

THERAPEUTIC MASSAGE - CLIENT INTAKE FORM

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

Varicose Veins

Allergies / Sensitivity

Pregnancy

Arthritis / Tendonitis

Blood Clots

Cancer / Tumours

Neck / Back Injuries

TMJ Issues

Diabetes

Abnormal Skin Condition

Paralysis

Heart / Circulation Problems

Fibromyalgia

Joint Replacement / Surgery

Numbness

High / Low Blood Pressure

Sprains / Strains

Major Accident

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? _____

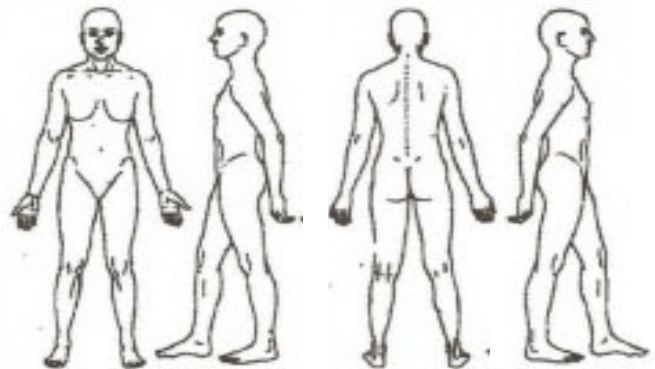
Do you know what caused it or when the symptoms seem to get worse or better?

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 contact has been made to the therapist. Your missed appointment affects the therapists time and bottom-line.

Signature _____ Date _____