

Client Intake Form



Client Contact Information

Client Name: _____

Date: _____

Date of Birth: _____ Gender: _____

Address: _____

Phone: _____ Email: _____

Referred by: _____

Emergency contact: _____ Phone: _____

Massage Information

Have you ever received professional massage/bodywork before? Yes No

How recently? _____

What types of massage/bodywork do you prefer? _____

What kind of pressure do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving massage/bodywork?

How do you feel today? _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No

Explain:

List the medications you currently take:

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment? _____

Circle any of the following health conditions that you currently have (If you are unsure, Please Ask):

PREGNANCY; BLOOD CLOTS; INFECTIONS; CONGESTIVE HEART FAILURE; CONTAGIOUS DISEASES; PITTED EDEMA

Please answer honestly, as massage may not be indicated for the above conditions.



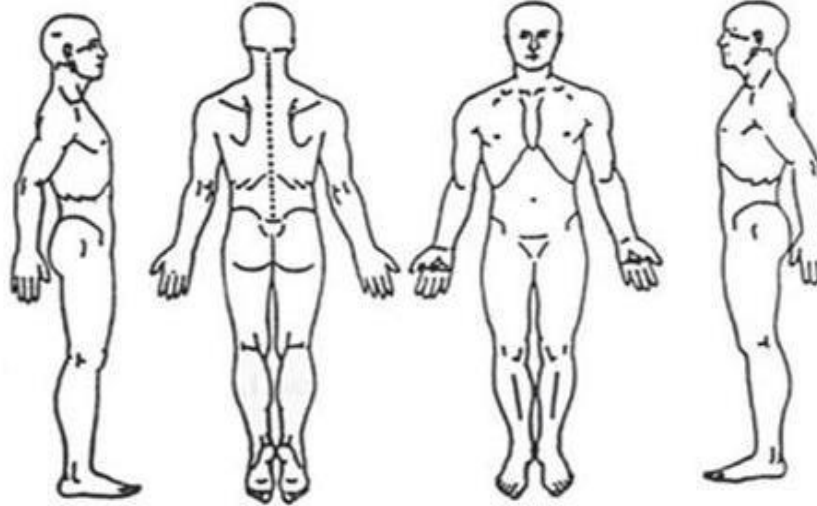
Client Intake Form (Back)



Are you experiencing any of the following:

- Pain: __Yes __No
 Numbness: __Yes __No
 Stiffness: __Yes __No
 Stress: __Yes __No
 Allergies: __Yes __No

PLEASE CIRCLE ANY AREAS OF DISCOMFORT



PLEASE READ THE FOLLOWING AND SIGN BELOW:

- **This massage is NON sexual in nature.** Please understand that any illicit or sexually suggestive remarks or advances made by the client will result in immediate termination of the session and full payment will be required. We do not treat erectile dysfunction, for that, you need to see a medical doctor.
- I understand that this massage is not a replacement for medical care and that no medical treatment or diagnosis will be made. It is recommended that I concurrently work with my Primary Caregiver for any condition I may have. The therapist does not prescribe medications nor physically manipulate the spine.
- I have provided a detailed medical history. I do not expect the therapist to have foreseen any previous or pre-existing condition that I have not mentioned. I will keep the practitioner updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.
- If I experience any pain or discomfort, I will immediately notify the therapist/practitioner so that the pressure methods can be adjusted to my comfort level.
- I also understand that massage therapy may produce some side effects such as muscle soreness, mild bruising, increased awareness of areas of pain and light headedness, among other possible temporary outcomes.
- I understand that massage therapy may provide benefits for certain conditions, but results are not guaranteed. These benefits may include relief of muscular tension, relaxation, reduction in symptoms of stress-related conditions and provision of general well-being.
- I understand that there is a \$25.00 appointment cancellation fee if less than 24 hours notice is given.
- **According to Maryland Law**, clients must remain draped by a sheet throughout the massage.
- By signing below, I state that the above information is true and correct to the best of my knowledge and state that I am not currently suffering from any ailment which could be adversely affected by massage and hereby waive and release Massage 911 Wellness Center and its therapists/practitioners from any and all liability, present and future.

Client Signature: _____

Date: _____

Parent or Guardian Signature (in case of a minor): _____

Date: _____





MEMBER
Associated Bodywork & Massage Professionals