East County Wellness Center

Massage Client Intake Form

Welcome to East County Wellness Center. We would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let us know.

Personal Client Information

Date _____

Name_____ ○ Male ○ Female

Home Phone _____Work Phone _____

Cell Phone _____ Email _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Occupation _____

Emergency Contact _____Relation _____ Phone _____

Referred By: _____ Phone _____

Would you like to be notified via mail of specials and seasonal discounts? ○ Yes ○ No

General and Medical Information

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Date of Initial Visit _____

1. Have you ever had a professional massage before? ○ Yes ○ No
2. If yes, how often do you receive massage therapy? _____
3. Do you have any difficulty lying on your front, back, or side? ○ Yes ○ No
4. If yes, please explain: _____
5. Do you have any allergies to oils, lotions, or ointments? ○ Yes ○ No
6. If yes, please explain:_____
7. Do you have sensitive skin? ○ Yes ○ No
8. Are you wearing contact lenses ○ dentures ○ a hearing aid ○ ?
9. Do you sit for long hours at a workstation, computer, or driving? ○ Yes ○ No
10. If yes, please explain: _____
11. Do you perform any repetitive movement in your work, sports, or hobbies? ○ Yes ○ No
12. If yes, please explain: _____
13. Do you experience stress in your work, family, or other aspects of your life? ○ Yes ○ No
14. If yes, please explain: _____
15. Muscle tension ○ anxiety ○ insomnia ○ irritability ○ other ○
16. Is there a particular area of the body where you are experiencing tension, stiffness, pain and/or other discomfort? ○ Yes ○ No
17. If yes, please explain: _____
18. Do you have any particular goals in mind for this massage session? ○ Yes ○ No
19. If yes, please explain: _____
20. Are you pregnant? ○ Yes ○ No
21. If yes, please explain how far along are you in the pregnancy: _____
22. Are you currently under medical supervision? ○ Yes ○ No
23. If yes, please explain: _____
24. Are you currently taking any medications? ○ Yes ○ No
25. If yes, please list them: _____
26. Is there anything else about your health history that you believe would be useful to know for your massage practitioner to plan a safe and effective massage session for you?

Please check off any of the following conditions or symptoms which apply to you:

____ Serious Injuries ____ Blood Clots ____ Varicose Veins ____ Stroke ____ High Blood Pressure ____ Low Blood Pressure ____ Contagious condition	____ Arthritis ____ Diabetes ____ Headaches ____ Skin Infections ____ Heart Attack ____ Recent Surgery ____ AIDS		____ Back Pain ____ Use of Tobacco ____ Contact Lenses ____ Allergies ____ Allergies to perfumes/oils ____ Other If other, please explain below:

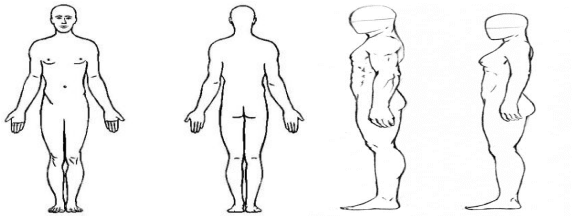
Comments: _____

_____

_____

_____

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



What are your massage or bodywork goals? _____

_____

_____

What kind of pressure do you prefer? Light ○ Medium ○ Firm ○

Draping will be used during the session - only the area being worked on will be uncovered.

Massage Therapy Inform Consent

I, (print name), understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of.

I understand that massage therapists 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 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability to East County Wellness Center, the employees, and the therapist's part should I fail to do so.

Please take a moment to read and initial all of the following statements:

If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold East County Wellness Center, the employees, or my therapist responsible for any pain or discomfort I experience during or after the session.

_____I affirm that I have notified my therapist of all known medical conditions and injuries.

_____I understand that massage is entirely therapeutic and non-sexual in nature.

_____I have received the policy statement, and have read and agree to the policies therein.

_____By signing this release, I hereby waive and release East County Wellness Center from any and all liability, past, present, and future relating to massage therapy and bodywork.

Consent to treatment of a Minor: By my signature below, I hereby authorize East County Wellness Center to administer massage, bodywork, and/or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent/Guardian _____ Date _____

Client's Name _____

Client's Signature _____ Date _____

Therapist's Name _____

Therapist's Signature _____Date _____