



Massage & Body Work Client Intake Form

Name _____ Date of birth _____ Age _____
Address _____ Phone _____
City _____ State _____ Zip _____ Sex M F OTHER
Email _____ Weight _____ Height _____

Reason for Visit

Primary reason for visit? _____

When did you first notice it? _____

What brought it on? _____

Describe any stressors occurring at the time _____

What activities provide relief? _____

What makes it worse? _____

Is the condition getting worse? Y N Interfere with work? Y N Sleep? Y N Recreation? Y N

History

Exercise frequency: _____ Exercise type: _____

How much water do you drink per day? _____

Current medications and/or supplements, remedies: _____

Allergies (specific allergen & reaction): _____

Injuries/surgeries (year & type): _____

Falls or injuries to the sacrum/head/tailbone? Y N If yes, please describe: _____

Accidents, traumas or other: _____

Goal(s) for today: _____

Long term goals: _____

Have you had massage therapy/body work before? Y N How often? _____

Are you pregnant? Y N If yes, how far along are you? _____

How many pregnancies have you had? _____ Births? _____ Terminations? _____

Do you use any methods of birth control? Y N If yes, what type? _____

Do you have any issues or concerns relating to these topics? Circle all that

Y N Gastrointestinal
 Y N Pregnancy / menopause
 Y N Male reproductive history

Y N Lifestyle, emotional &/or spiritual
 Y N Female reproductive history
 If yes to any, please explain: _____

Do you currently have, or have you had in the past, any of the following? Check all that apply.

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Trouble getting pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Erectile dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cuts, burns, bruises	<input type="checkbox"/>	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Severe pain	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Fibroids
<input type="checkbox"/>	<input type="checkbox"/>	Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal
<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash
<input type="checkbox"/>	<input type="checkbox"/>	Painful/irregular menses	<input type="checkbox"/>	<input type="checkbox"/>	Pain when stooling	<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Pins/pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis

Areas of discomfort? Check all that apply.

<input type="checkbox"/> Head	<input type="checkbox"/> Wrist	<input type="checkbox"/> Hips	<input type="checkbox"/> Calves
<input type="checkbox"/> Neck	<input type="checkbox"/> Hand	<input type="checkbox"/> Glutes	<input type="checkbox"/> Feet
<input type="checkbox"/> Shoulders	<input type="checkbox"/> Upper back	<input type="checkbox"/> Hamstrings	<input type="checkbox"/> Ankles
<input type="checkbox"/> Upper arm	<input type="checkbox"/> Mid back	<input type="checkbox"/> Quads	
<input type="checkbox"/> Lower arm	<input type="checkbox"/> Lower back	<input type="checkbox"/> IT Bands	

Additional comments: _____

Client Confidentiality & Release

I understand this modality is not a replacement for medical care. The practitioner does not diagnose medical illness, disease, physical and mental conditions or perform spinal manipulations unless specified under their professional scope of practice. The practitioner may recommend referral to a qualified health professional for any physical or emotional conditions I may have. I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.

Signature _____

Date _____

Massage & Body Work Client Waiver Form

Please take a moment to read and check the boxes for the following information:

- If I experience pain or discomfort during the session, I will immediately inform my provider so that the pressure/strokes can be adjusted to my level of comfort. I will not hold my provider responsible for any pain or discomfort I experience during or after the session.
- I understand the services offered today are not a substitute for medical care. I understand that my provider is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat physical or mental illness.
- I affirm that I have notified my provider of all known medical conditions and injuries.
- I agree to inform my provider of any changes in my health and medical condition. I understand that there shall be no liability on the providers part should I forget to do so.
- I understand massage and body work is entirely therapeutic and non-sexual in nature.
- I understand and consent to fire cupping, should that be part of the session that the patient and massage therapist has agreed upon. This technique helps relieve symptoms in which cups made of glass are placed on the skin with a vacuum created by heat.
- By signing this release, I hereby waive and release my provider from any and all liability, past, present and future relating to massage and body work and understand the potential risks and benefits.
- I have reviewed the policy statement and have read and agreed to the policies therein.

Client name _____

Client signature _____

Provider signature _____ Date _____

Information & Suggestions

- Prior to your massage/body work, please remove all jewelry.
- Pull long hair back with a clip or band.
- In general, massage and body work is given while you are unclothed. You will be covered with a top sheet throughout your session. This is your session and you should be as comfortable as possible!
- Feel free to ask Anthony any questions before, during or after your session. Anthony s a highly trained professional and will be happy to make you feel informed and comfortable.

