**Confidential Client Intake and Informed Consent Form**

**Personal Information:**

Name: _____ Gender: Female Male Date: _____

Date of Birth: _____ Age: _____ Referred by: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Emergency Contact: _____ Phone: _____

Reason and/or goal for today's visit: _____

Have you had a professional massage before? Yes No When was your most recent massage? _____

Are there any areas (e.g. feet, face) that you would prefer not to have worked on? _____

**Current Condition (if any):**

Primary area of complaint: _____

Symptoms you are experiencing: _____

When and how did this condition develop? _____

Who have you seen for this condition (e.g. doctor/PT/chiropractor)? _____

**Medical Information: (Please use the back of this form if you need additional space.)**

List all medications and/or conditions you are currently taking medicine for: _____

_____

*Women only:* Are you pregnant? Yes No If yes, when is your due date? _____

Please place an "**X**" next to any of the following conditions that apply to you, now or in the past:

| | | | |
|---|---|---|---|
| ( ) Arthritis | ( ) Heart Disease | ( ) Hernia | ( ) Allergies/Sinus Issues |
| ( ) Osteoporosis | ( ) Heart Attack | ( ) Abdominal Pain | ( ) Asthma |
| ( ) Cancer | ( ) Stroke | ( ) Constipation | ( ) Headaches/Migraines |
| ( ) Circulatory Issues | ( ) High Blood Pressure | ( ) Diarrhea | ( ) Spinal/Skeletal Problems |
| ( ) Blood Clots | ( ) Low Blood Pressure | ( ) Skin Problems | ( ) Numbness/Tingling |
| ( ) Varicose Veins | ( ) Swelling/Edema | ( ) Mental Illness | ( ) Hearing Impaired |
| ( ) Diabetes | ( ) Dizziness or Fainting | ( ) Insomnia | ( ) Vision Impaired |
| ( ) Seizures | ( ) Neurological Problems | ( ) Fatigue | ( ) Dislocated shoulder L/R |

( ) Infectious/Contagious Conditions: _____

( ) Surgeries, Accidents, or Injuries: _____

( ) Other: _____

**Informed Consent and Waiver of Liability:**

- Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions. I agree to keep the massage therapist updated as to any changes in my medical profile and understand that there shall be no liability on the massage therapist's part should I fail to do so.
- I understand that: 1) The massage therapy I am given is for the purpose of relaxation, stress reduction, and relief from chronic pain or muscular tension; 2) A massage therapist neither diagnoses illness, disease, or other medical, physical, or mental disorders, nor performs any spinal manipulations. 3) The massage therapist will only work within the scope of her practice.
- I agree that if I experience any pain or discomfort during the session, I will immediately communicate this to the massage therapist so the pressure and techniques can be adjusted to my comfort level.
- I agree that all services rendered are charged directly to me, and I am responsible for payment at the time the service is provided.

**Signature:** _____ **Date:** _____