

**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: \_\_\_\_\_ 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:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Hernia                | <input type="checkbox"/> Allergies/Sinus Issues   |
| <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Heart Attack          | <input type="checkbox"/> Abdominal Pain        | <input type="checkbox"/> Asthma                   |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Stroke                | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Headaches/Migraines      |
| <input type="checkbox"/> Circulatory Issues | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Spinal/Skeletal Problems |
| <input type="checkbox"/> Blood Clots        | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Skin Problems         | <input type="checkbox"/> Numbness/Tingling        |
| <input type="checkbox"/> Varicose Veins     | <input type="checkbox"/> Swelling/Edema        | <input type="checkbox"/> Mental/Depression/Anx | <input type="checkbox"/> Hearing Impaired         |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Dizziness or Fainting | <input type="checkbox"/> Insomnia              | <input type="checkbox"/> Vision Impaired          |
| <input type="checkbox"/> Seizures           | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> 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: \_\_\_\_\_