Massage Green — Client Intake Form

Date: ____________________

NAME: ____ **BIRTHDAY** ____/_____/______

ADDRESS_________________________________ **CITY/STATE/ZIP**____________________________

HOME PHONE#_____________________________ **CELL PHONE#**____________________________

EMAIL: ____________________________________ **OCCUPATION:**___________________________

EMERGENCY CONTACT:________________________________ **PHONE#**______________________

THE FOLLOWING INFORMATION WILL BE USED TO HELP PLAN SAFE & EFFECTIVE MASSAGE SESSIONS EACH TIME YOU VISIT US.

****** Your contact and personal information is for Massage Green use only and will not be shared with any person or entity outside of Massage Green.***

IT IS IMPORTANT THAT YOU ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE AND HONESTY. THANK YOU.

Have you had professional massages before? Y N If yes, how often are your massages? ______________________

Do you have difficulty lying on your front, back or sides? Y N Explain: ____

Do you have allergies to any oils, lotions or ointments? Y N Explain: ____

Do you have sensitive skin? Y N Are you wearing contacts? Y N Hearing Aids? Y N Dentures? Y N

Do you sit for long hours at a workstation such as a computer or driving? Y N Describe: ___________________________

Do you perform repetitive movement in your work, sports or hobby? Y N Describe: _______________________________

Do you have stress in your work, family or other aspect of your life? Y N How do you feel this has affected your health?

WITH: Muscle Tension ( ) Anxiety ( ) Insomnia ( ) Irritability ( ) Other____________________________________

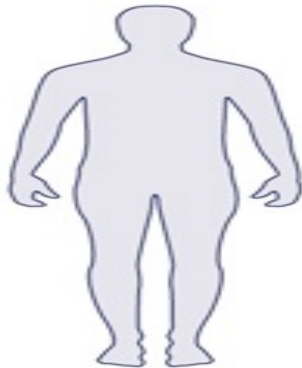
Is there a particular area of the body where you are experiencing TENSION? STIFFNESS? PAIN? OTHER?

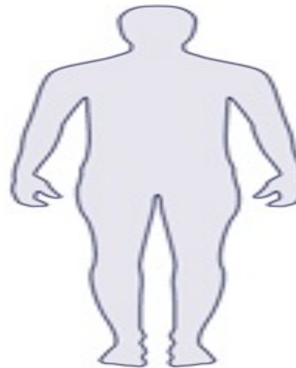
Identify with detail: ____

Do you have any particular goals in mind for this massage session? Y N

If yes, please describe: __________________ ____

What areas of your body would you like the massage therapist to concentrate on during this session:





MEDICAL HISTORY

To plan a massage session that is safe & effective, please share some general medical history:

Are you currently under medical supervision? Y N If YES, please explain: ___________________________________

Do you see a Chiropractor? Y N If yes, How often? ____

Please list ANY medications, prescribed or OTC: ____

Please Check the Conditions below that apply to you:

( ) Contagious Skin Condition
( ) Open Sores or Wounds
( ) Easy Bruising
( ) Recent Accident/Injury
( ) Recent Fracture
( ) Recent Surgery
( ) Joint Replacement
( ) Sprains/Strains
( ) Current Fever/Chills
( ) Swollen Glands
( ) Allergies/Sensitivities
( ) Heart Condition

( ) Pacemaker
( ) High/Low Blood Pressure
( ) Circulatory Disorder
( ) Varicose Veins
( ) Atherosclerosis
( ) Phlebitis
( ) Blood Clots/Deep Vein Thrombosis
( ) Joint Disorder/Arthritis
( ) Osteoporosis
( ) Epilepsy
( ) Headaches/Migraines
( ) Cancer

( ) Diabetes
( ) Numbness
( ) Back/Neck Issues
( ) Fibromyalgia
( ) TMJ
( ) Carpal Tunnel
( ) Tennis Elbow
( ) Pregnancy Months? _____
( ) Frozen Shoulder
( ) Swelling Where? ______

PLEASE EXPLAIN ANY CHECKED CONDITIONS LISTED ABOVE: ____

IS THERE ANYTHING ELSE ABOUT YOUR CURRENT HEALTH HISTORY THAT YOU THINK WOULD BE USEFUL FOR YOUR THERAPIST TO BE AWARE OF TO MAKE THIS A BETTER SESSION. ____

DRAPING WILL BE USED DURING THIS SESSION. Only the body area being worked on will be uncovered. Clients under the age of 17 must have a parent or legal guardian present to provide a signature for authorization of the therapeutic massage session.

I,____ 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 to any changes in my medical profile and understand that there shall be no liability on the therapists part should I fail to do so. I understand that if I am uncomfortable for any reason I may ask the therapist to cease the massage and I will end the massage session.

CLIENT INITIALS: _________

Any illicit or sexually suggestive behavior either physical or verbal made by me, will result in immediate termination of the session. I will be liable for the "full" scheduled appointment and may be reported to the appropriate authorities.

Signature of Client: ____**Date:**______________________

Massage

Signature of Therapist: ____**Date:**_______________________

The type of massage therapy service or techniques that I anticipate using during the massage therapy session is:

The therapist shall not engage in any type of breast massage of female clients without the written consent of the client.

Therapist Notes: ____

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Massage