DEFINED: THERAPEUTIC MASSAGE

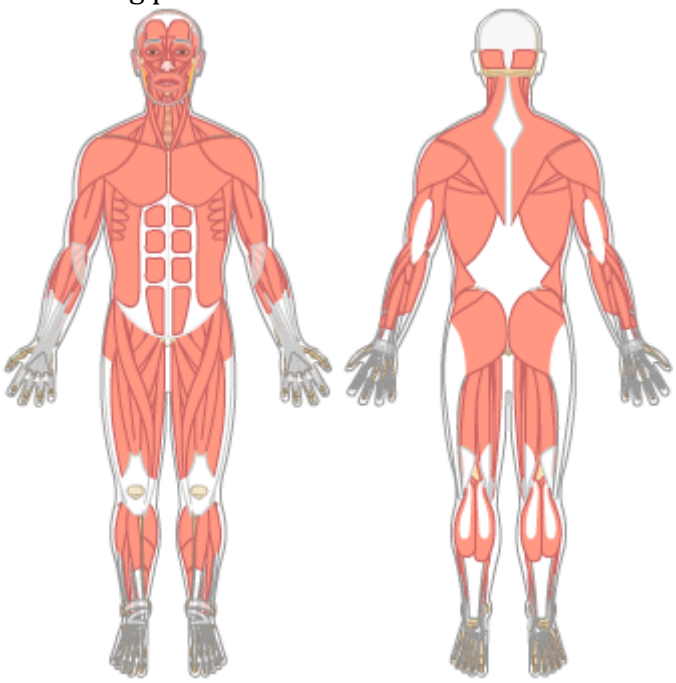
Client Intake Form "Taking a Personalized Approach to **YOUR** Therapeutic Massage Needs"

Contact Information

Name: (last, first) _____ Phone:(best)_____ (alt.)_____
Street Address: _____ City: _____ State: _____ Zip: _____
E-mail: _____ D.O.B.: _____ Occupation: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Physician: _____ Phone: _____ Currently Under Care: **(Y/N)** for what: _____

Massage Information

Date of Initial Visit: _____
Previous Massage: **(Y/N)** Last: _____
Where: _____
What are your goals for this treatment:
_____
Please indicate on the images below where you are having pain or difficulties:



Therapist's Notes:

Health History

Chronic Pain/Discomfort: **(Y/N)**How Long: _____
Where is this pain located: _____
Trouble sleeping: **(Y/N)** from what: _____
Do you exercise: **(Y/N)** how frequent: _____
What type of exercise: _____
What medications/vitamins/supplements are you currently taking: _____
_____
Do you smoke: **(Y/N)** Consume Alcohol: **(Y/N)**
Consume Caffine: **(Y/N)**
Please indicate below by the following key if you have or have had any of these conditions: **C** = current / **P** = past **F** = family history / **N** = never
___ Headaches/Migraines ___ High/Low Blood Pressure
___ Diabetes (Type I or II) ___ Fibromyalgia ___ Asthma
___ Arthritis/Tendonitis ___ Depression ___ Epilepsy
___ Herniations ___ Dizziness ___ Varicose Veins
___ Skin Conditions ___ Cancers/Tumors ___ Bruise Easily
___ Joint Replacement ___ Sensitivities ___ Pregnant
___ Heart Condition ___ Emotional Disorders ___ Surgeries
___ Recent Accidents ___ Major Accidents ___ Pins/Screws
___ HIV ___ Hepatitis(A, B, C) ___Other:_____
_____
Explain any above conditions in more detail please:

How did you hear about **DEFINED**: Therapeutic Massage?
We like to give a special thanks to those who support D:TM's work, so please list what form of marketing brought you to the office:_____

Agreements

Important: Massage practitioners do not diagnose or prescribe for disease. Professional massage does not replace medical care, but complements it. Massage practitioners are trained to recognize certain conditions for which massage is contraindicated and to refer clients to medical doctors or other health professionals when appropriate. **Please read and agree by signing off on the statements below.**

Health Agreements

I understand that an accurate health history is important to ensure that it is safe for me to receive massage therapy. I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes**.** **Please Initial: _____**

I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns about my therapy immediately. **Please Initial: _____**

Financial Agreements

If the massage is terminated by either the client or the therapist, I am responsible for the payment due based on the time spent together. **Please Initial: _____**

I agree to provide **24 hours cancellation notice**. If I fail to do so, I agree to pay for my missed session in full, plus any additional billing fees. **Please Initial: _____**

I understand that the massage therapy that I am given is for the purpose of stress reduction, relief from muscular tension or spasm, and/or improving circulation as well as overall general well-being. *The massage to be given is a NON-SEXUAL massage and any sexual advances will not be tolerated by either party*. I understand that a massage therapist neither diagnoses illness, disease, or any other medical, physical or mental disorders; nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailment I may have.

Client Signature:_____ Date:_____
If under 18, Parent/Guardian Signature_____ Date:_____
Therapist Signature: _____ Date:_____

Move, Feel, & BE Better

Additional Therapist Notes: