That Massage Place

Professional Massage Therapy

411 Freeport Road
Aspinwall, Pa 15215

CLIENT INTAKE AND INFORMATION

Name: _____ Date of Birth: _____
Phone: _____ Referred By: _____
Address: _____
City & Zip: _____ Emergency Contact: _____
Email: _____ Phone: _____

HEALTH & MEDICAL HISTORY

Are you taking any prescribed medications? _____
_____
_____

Are you taking any supplements, herbs, over the counter medications, or known blood thinners? _____
_____
_____

Do you have any known allergies? _____
_____

Are you currently experiencing:

- ☐ Cold / Flu
- ☐ Burns / Sunburn
- ☐ Headaches / Migraines
- ☐ Fever or Infections
- ☐ Numbness / Tingling
- ☐ Arthritis / Tendonitis
- ☐ Muscle Sprains / Strains
- ☐ Skin Conditions
- ☐ Cuts / Bruises
- ☐ Contagious, Viral or Fungal Infections
- ☐ Recent Tattoos / Piercings
- ☐ Pregnancy

Have you ever been diagnosed with, or been advised to seek treatment for:

- ☐ High / Low Blood Pressure
- ☐ Varicose Veins
- ☐ Respiratory Conditions
- ☐ Stroke / TIAs
- ☐ Bruising / Blood Conditions
- ☐ Spinal / Bone Disorders
- ☐ Diabetes / Blood Sugar Control
- ☐ Lymphatic Conditions
- ☐ Nerve Disorders
- ☐ Heart Disease
- ☐ Kidney / Bladder Conditions
- ☐ Seizures
- ☐ Blood Clots / Aneurysm
- ☐ Depression / Anxiety
- ☐ Cancer

Do you have any other conditions not mentioned above, or wish to provide more detail about a condition you checked?
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

What are your goals for your massage session(s)? _____
_____
_____
_____

Therapist's Notes: _____
_____
_____
_____
_____
_____
_____

Have you experienced any of the following in the last 5 years:

☐ Hospitalization or Surgery ☐ Accidents or Trauma ☐ Broken or Dislocated Bones

If yes, please explain further: _____

_____

_____

_____

MASSAGE HISTORY

Have you ever had therapeutic massage before? Yes / No

Do you have specific likes or dislikes regarding massage? _____

_____

_____

What is your Occupation?_____

What stresses do you most often put on your body? This could including desk work, sports, hobbies or even being sedentary:

_____

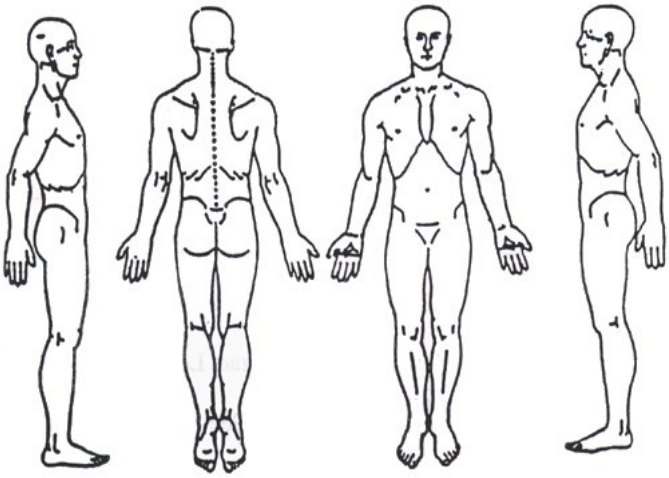
_____

_____

What level of pressure will be most comfortable to you?

Lighter _____ Moderate _____ Heavier

Please circle any areas on the body sketches below where you are experiencing pain, tension, etc., If there are areas of the body that you would specifically like avoided during massage for any reason, place a small X over them:



PLEASE READ AND SIGN:

Massage is provided for the basic purpose of relaxation, stress reduction and relief for muscular tension. Massage services are designed to be a health aid and in no way are meant to take the place of a physician's care. Information exchanged during a massage session is educational in nature and is intended to help broaden awareness and not to treat, diagnose or cure any condition.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions and answered all questions honestly and I understand that it is my responsibility to keep the massage therapist updated as to any changes in my medical profile.

I also understand that:

- Any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and full payment for the scheduled session will be due.
- Payment is due when services are rendered unless other arrangements have been made prior to my appointment.
- I will give 24 hour notice if I cannot keep an appointment.

Signature: _____ Date: _____

Evaluated By Therapist: