Tranquil Transitions Mind and Body Wellness

Massage Therapy Client Intake Form

Name:_____

Address: _____ City: _____ Sate: _____ Zip: _____

Mobile/Home Phone: _____ Work/Other: _____

E-mail: _____

Occupation: _____

Emergency Contact: _____ Phone: _____

Are you currently under a physician's care for an acute or chronic illness? Y ___ N ___

If yes, please explain: _____

If yes, who is your health care provider: _____

Are you currently taking any prescribed medications or dietary supplements? Y ___ N ___

If yes, please explain: _____

Have you received a massage before? Y ___ N ___ If yes, when: _____

Who referred you: _____

What are your goals for this session: _____

Health information

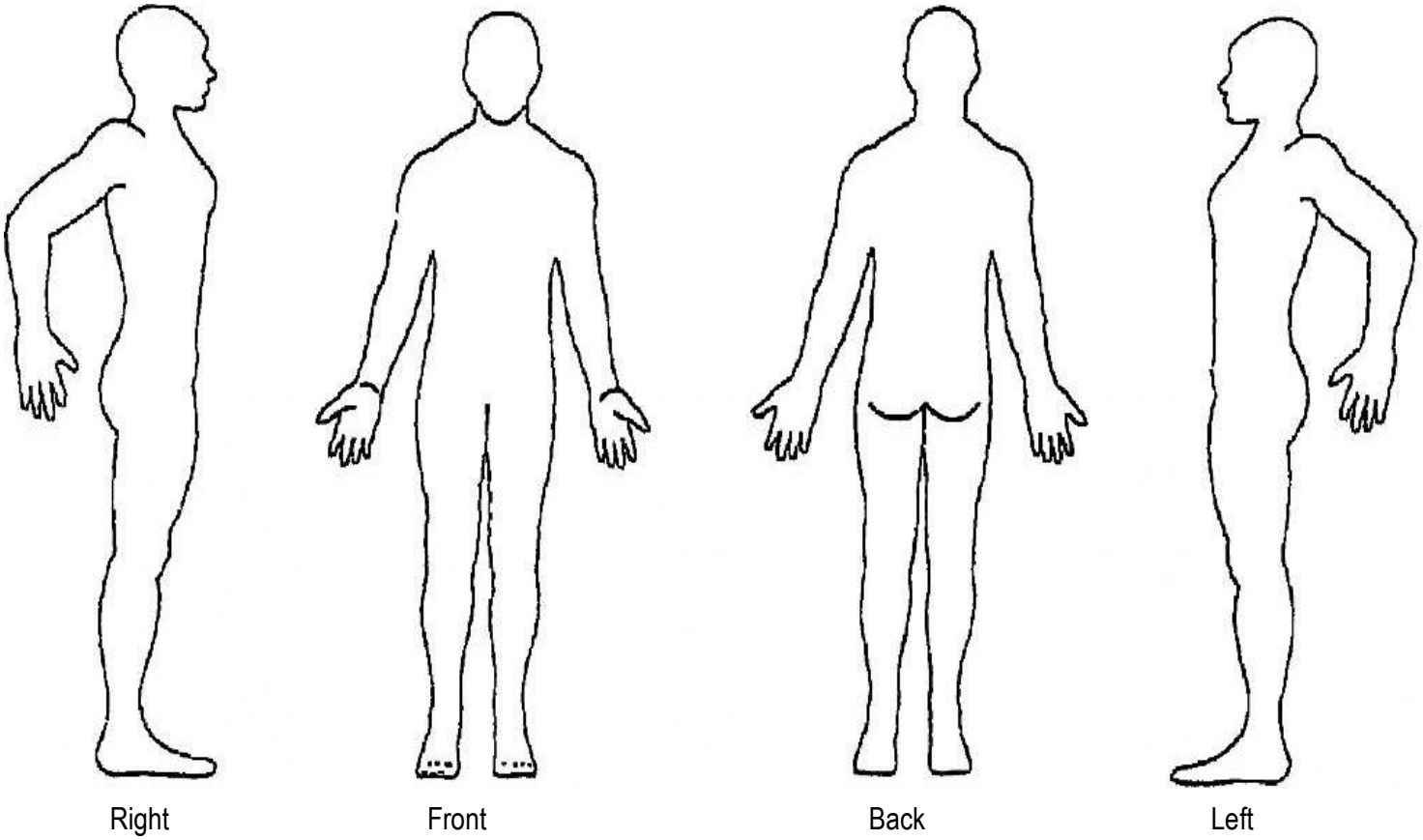
Please mark an (X) by all current conditions and (P) for all past conditions:

___ Abdominal/digestive
___ Allergies
___ Anxiety
___ Arthritis/tendonitis
___ Asthma/lung conditions
___ Athlete's foot
___ Blood clots
___Chronic pain
___ Circulatory/heart
___ Constipation/diarrhea
___ Depression
___ Diabetes
___ Fatigue
___ Headaches/migraines
___ Hearing problems
___ Hernia
___ High blood pressure
___ TMJ/jaw pain
___ Low blood pressure
___ Muscle/bone injury
___ Muscle/joint pain
___ Numbness/tingling
___ Pregnancy
___ Rash/fungus
___ Sinus problems
___ Sleep difficulties
___Spinal disorders
___ Sprain/strain
___ Tension/stress
___ Vision problems
___ Varicose veins
___ Other
_____

Elaborate on noted areas above: _____

Please list any recent injuries or surgeries (past 5 years): _____

Place a circle or place an (X) next to any areas of tension or discomfort:



I have stated all conditions that I am aware of, and this information is true and accurate to the best of my knowledge. I will inform my health care provider and massage therapist if anything changes in my status. I understand that massage/bodywork I receive is for the purpose of stress reduction and the relief from muscular tension, spasm, or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform my massage therapist so that the pressure and/or methods can be adjusted to my comfort level. I understand that my massage therapist does not diagnose illness or disease, nor perform any spinal manipulations, and does not prescribe any medications/treatments. I acknowledge that massage is not a substitute for a medical examination or diagnosis and that I should see my health care provider for those services. If I am unable to attend my scheduled appointment, I will respect and abide by the set cancellation policies. Sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated. I understand that I am receiving massage therapy at my own risk. If I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.

Signature: _____ Date: _____