The Massage Center

Client Intake Form Page 1 of 2

PLEASE PRINT LEGIBLY

Name _____ Email _____
Address _____ City:_____ State ___ Zip _____
Phone: Home_____Work_____Cell_____ Birth Month _____ Birth Year _____
Occupation _____ How did you hear about us? _____
In Case of Emergency Please Contact _____Phone_____

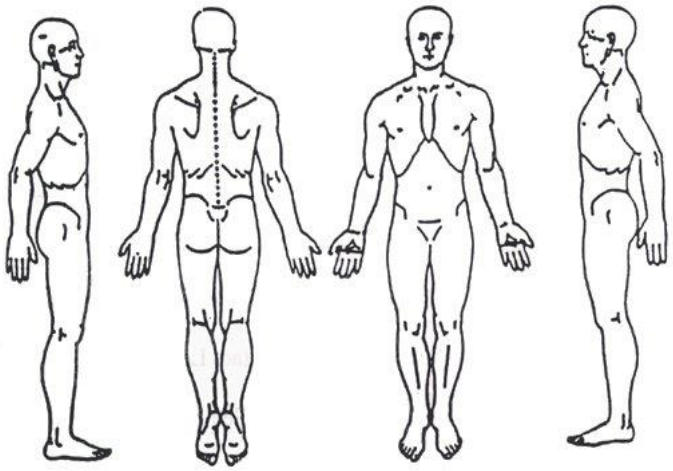
General and Medical Information (Please circle Y for YES or N for No)

Have you ever had a professional massage? Y / N If yes, how often? _____
Are you pregnant? Y / N If yes, how far along are you?_____
Are you sensitive to touch/pressure in any area? Y / N Ticklish? Y / N
Are you allergic or sensitive to any oils (essential oils, nut oils, scents)? Y / N If yes, please list:_____
List of current medications and reason:_____
List of surgeries (type and date): _____
On a scale from 1-10, 10=highest, rate your levels of: Stress _____ Pain _____ Energy _____
How did your symptoms begin and when did they start? _____
What have you done for relief? _____
Is the condition getting better/worse? (circle one)

Please check all that apply: □ Skin Problems □ Rash □ Warts □ Hives □ Skin cancer □ Lymphatic Problems
□ Swollen Gland □ Nasal Congestion □ Lymph Edema □ Joint Problems □ Stiffness
□ Arthritis □ Sacroiliac Problems □ TMJ □ Bone Condition □ Osteoporosis □ Fracture
□ Headaches □ Recent injury: _____ □ Accident:_____ □ Whiplash
□ Sprain □ Bruise □ Cut □ Scratch □ Any other type of injury at all_____
□ Circulatory Problems □ High Blood Pressure □ Varicose Veins □ Blood Clots □ Numbness / Tingling □ Sciatica
□ Tendonitis □ Bursitis □ Diabetes □ Other: _____ Describe your problem areas:_____
□ Hepatitis □ HIV/AIDS □ Cancer □ Seizures Any ailment, disease or problem not listed here:_____

Would you like to receive a free spinal exam from a chiropractic physician? (circle one) Yes or No

Please mark in the diagram below to show any areas where you have pain or discomfort.



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Massage Therapy Client Waiver

Please take a moment to read and initial all of the following statements

If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.

_____
I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

_____
I affirm that I have notified my therapist of all known medical conditions and injuries.

_____
I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.

_____
I understand that massage is entirely therapeutic and non-sexual in nature.

_____
By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

_____
I understand that should I cancel an appointment less than 24 hours before the scheduled time or "no show" an appointment, I am subject to a fee equal to the cost of the missed appointment. This fee is monetary & can't be taken as an additional "punch" off a massage package card. If the appointment was booked under a gift certificate, it will be voided in lieu of the fee.

_____
Information and Suggestions
• Prior to your massage, please remove contact lenses and all jewelry. Pull long hair back with a clip or band.
• In general, massage is given while you are unclothed. However, you may choose to wear undergarments or a swimsuit. You will be covered with a top sheet throughout your session. This is your massage and you should be as comfortable as possible.
• Feel free to ask your therapist any questions before, during, or after the session. Your therapist is a highly trained professional and will be happy to make you feel informed and comfortable.

I have received the policy statement, and have read and agree to the policies therein.

Client Print Name:_____

Client signature:_____

Date:_____

Therapist signature:_____