Absolute Balance Bodywork

Confidential Client Intake Form – Therapeutic Massage

Name _____ Phone (Day) _____ Phone (Eve) _____

Address _____ City _____ State _____ Zip Code _____

Email _____ Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Date of initial visit _____

1) Have you had a professional massage before? Yes ___ No ___

   If yes, how often do you receive massage therapy? _____

2) Do you have any difficulty lying on your front, back, or side? Yes ___ No ___

   If yes, please explain _____

3) Do you have any allergies to oils, lotions, or ointments? Yes ___ No ___

   If yes, please explain _____

4) Do you have sensitive skin? Yes ___ No ___

5) Are you wearing: contact lenses ( ) dentures ( ) hearing aid ( )?

6) Do you sit for long hours at a workstation, computer, or driving? Yes ___ No ___

   If yes, please describe _____

7) Do you perform any repetitive movement in your work, sports, or hobby? Yes ___ No ___

   If yes, please describe _____

8) Do you experience stress in your work, family, or other aspect of your life? Yes ___ No ___

   If yes, how do you think it has affected your health: muscle tension ( ) anxiety ( ) insomnia ( )

   irritability ( ) other _____

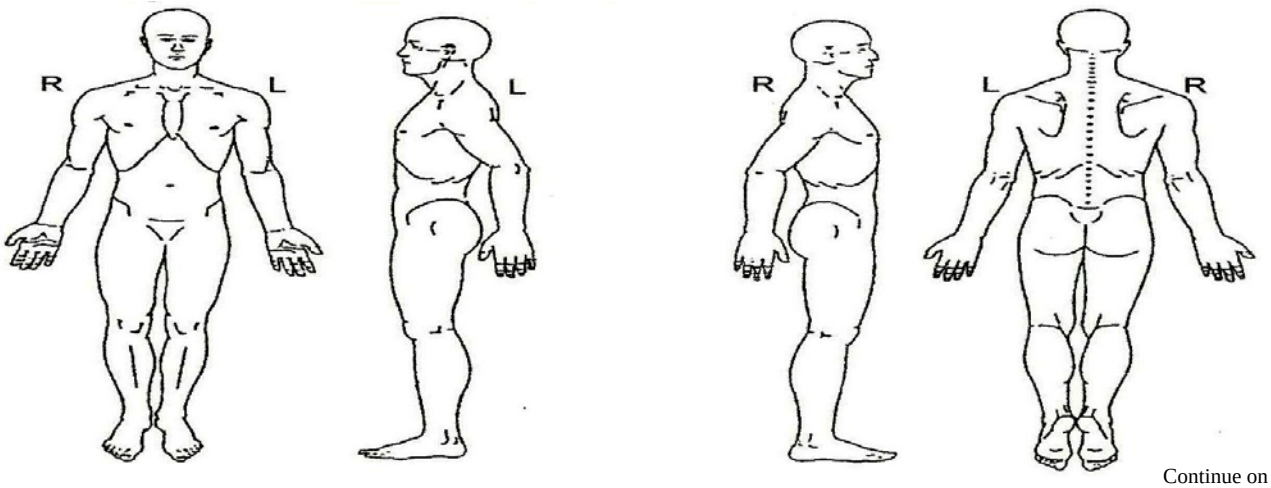
9) Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?

   Yes ___ No ___ If yes, please identify _____

10) Do you have any particular goals in mind for this massage session? Yes ___ No ___

    If yes, please explain _____

Please circle any specific areas you would like the massage therapist to concentrate on during this session:



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<u>Medical History</u> : In order to plan a massage session that is safe and effective, I need some general information about your medical history.

11) Are you currently under medical supervision? Yes ___ No ___

If yes, please explain _____

12) Do you see a chiropractor? Yes ___ No ___ If yes, how often? _____

13) Are you currently taking any medication(s)? Yes ___ No ___

If yes, please list _____

14) Please check any condition listed below that applies to you:

( ) contagious skin condition	( ) phlebitis	( ) open sores or wounds
( ) DVT / blood clots	( ) easy bruising	( ) recent accident or injury
( ) joint disorder / rheumatoid arthritis / osteoarthritis / tendonitis		( ) heart condition
( ) recent fracture	( ) osteoporosis	( ) recent surgery
( ) atherosclerosis	( ) epilepsy	( ) varicose veins
( ) headaches / migraines	( ) pregnancy *how many months? ____	
( ) artificial joint	( ) cancer	( ) circulatory disorder
( ) sprains / strains	( ) diabetes	( ) tennis / golf elbow
( ) current fever	( ) decreased sensation	( ) high or low blood pressure
( ) swollen glands	( ) back / neck problems	( ) carpal tunnel syndrome
( ) allergies / sensitivity	( ) Fibromyalgia	( ) TMJ

Please explain any condition that you have marked above: _____

_____

_____

15) Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you? _____

- Draping will be used during the session – only the area being worked on will be uncovered.
- Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session.
- Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief from 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 the 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 medial 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 as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Client signature _____ Date _____

Massage Therapist signature _____ Date _____