# Client Intake Form

The Massage Clinic of Poplar Bluff

Personal Information:

Name:_____ Phone (Cell)_____

Phone (Home)_____ Cell Provider_____

Phone (Work)_____Ext:_____Text Reminder? Y N

Address_____

Email_____Email reminder? Y N Newsletter sign up? Y N

Birth Date____/____/____ How were you referred to us?_____

Emergency Contact_____Relationship_____Phone_____

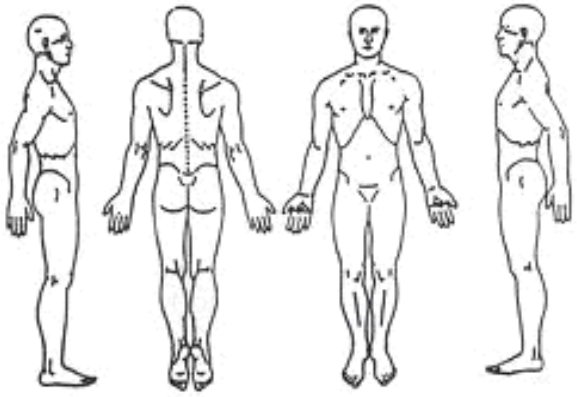
Occupation_____

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

Today's Date:_____

1. Have you had a professional massage before? Yes No
   If yes, how often?_____
2. Do you have any difficulty lying on your front, back or side? Yes No
3. Do you have any allergies to oils, lotions, or ointments? Yes No
4. Do you have sensitive skin? Yes No
5. Are you wearing contact lenses ( ) dentures ( ) a 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 hobbies? 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_____
11. Are you comfortable with bodywork in these areas? Please check all that apply. Gluteal/Hip ( ) Abdomen ( )
    Pectorals(upper chest) ( ) Face/scalp ( ) Feet ( )

Please indicate on the model where you are experiencing pain and would like focus in today's session



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## Medical History

To plan a massage session that is safe and effective, we need some general information about your medical history:

12. Are you currently under medical supervision? Yes No
If yes, please explain_____

13. Please list ALL medications and supplements 14. Please list ALL surgeries, most recent first

| | | | |
|---|---|---|---|
| 1 | 7 | 1 | 7 |
| 2 | 8 | 2 | 8 |
| 3 | 9 | 3 | 9 |
| 4 | 10 | 4 | 10 |
| 5 | 11 | 5 | 11 |
| 6 | 12 | 6 | 12 |

15. Do you see a chiropractor Yes No if yes, how often? _____

16. Please check any condition listed below that applies to you:

( )Contagious skin conditions
( )Deep Vein Thrombosis/blood clots
( )Osteoporosis
( )Sprain/strain_____
( )Diabetes
( )TMD
( )Circulatory disorder
( )Pregnancy, if yes how many weeks?_____
( )Joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( )Phlebitis
( )Easy bruising
( )Recent fracture
( )Headaches/migraines
( )Fibromyalgia
( )High/Low Blood Pressure
( )Tennis elbow
( )Atherosclerosis
( )Open sores or wounds
( )Recent accident or injury
( )Epilepsy
( )Cancer_____
( )Heart conditions
( )Carpal tunnel syndrome
( )Varicose veins
( )Artificial joint_____

Please explain any condition(s) that you have marked above_____

17. Is there anything else about your health history that you think would be useful for your massage practitioner 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 the relief of 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 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 medical 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. I also understand that if I am under the influence of alcohol or recreational drugs, the therapist has the right to deny treatment. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Signature of Client_____Date_____

Signature of Massage Therapist_____Date_____

Consent for treatment of a minor (17 and under). I (parent or guardian) _____
do hereby give consent for the massage therapist to treat _____.

Signature of parent or guardian_____ Date _____