HC3 Wellness Center

Massage Therapy Intake Form

Name _____ Phone ( ) _____ DOB _____

Address _____ City _____ State _____ Zip _____

E-mail: _____

Referred by: _____Phone ( )_____

In case of emergency: _____ Phone ( )_____

Male _ Female _

Physician_____Phone()_____

_____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? _ Yes _ No How recently?_____

What are your massage or bodywork goals?_____

Select your preferred touch __ light__ medium __ firm

_Yes _ No Do you frequently suffer from stress?	_ Yes _ No Do you bruise easily?
_ Yes _ No Do you have diabetes?	_ Yes _ No Any broken bones
_ Yes _ No Do you experience frequent headaches or migraines?	_ Yes _ No Any injuries?
_ Yes _ No Are you pregnant?	_ Yes _ No Do you have tension or soreness in a specific area? Please specify
_ Yes _ No Do you suffer from arthritis?	_ Yes _ No Do you have cardiac or circulatory problems?
_ Yes _ No Are you wearing contact lenses?	_ Yes _ No Do you suffer from back pain?
_ Yes _ No Do you suffer from joint swelling?	_ Yes _ No Do you have numbness or stabbing pains?
_ Yes _ No Do you have high or low blood pressure?	_ Yes _ No Are you sensitive to touch or pressure in any area?
_ Yes _ No Are you taking high blood pressure medication?	_ Yes _ No Have you ever had surgery? Explain below.
Yes No Have you ever had cancer?	_ Yes _ No Other medical condition, or are you taking any Medications I should know about?
_ Yes _ No Do you suffer from epilepsy or seizures?	
_ Yes _ No Do you have varicose veins?	
_ Yes _ No Do you have any contagious diseases?	Comments
_ Yes _ No Do you have osteoporosis?	
_ Yes _ No Do you suffer from scoliosis?	
_ Yes _ No Do you have any allergies?	

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I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and 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 or bodywork 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 of which I am aware. I understand that massage/bodywork 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/ bodywork 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 I will be liable for payment of the scheduled appointment.

Client Signature _____ Date _____

Therapist Signature _____ Date _____