**Transformations: A Wellness Collective**

**Massage Therapy Intake Form**

**Personal Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Daytime Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evening Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Massage Experience**

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a professional massage before? Y / N

If yes, when was your last massage? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of massage? (ex. Swedish, Deep Tissue, etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your goal for today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of pressure do you like? (Please Circle) Light----Medium----Firm----Deep

Are you *uncomfortable* with any of the following areas to be massaged:

*Gluteal Region (Y/N) Pectoral Region (Y/N) Face/Scalp (Y/N) Feet (Y/N)*

**Health History**

Please list any medications or supplements you are currently taking and explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any injuries/accidents/illnesses still affecting you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any surgeries and explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please identify the areas of concern on the chart below:

 

**Health History**

*Please circle Current or Past*

|  |  |  |  |
| --- | --- | --- | --- |
| Current Past | Add/Adhd? Autistic? Aspergers? | Current Past | High/ Low Cholesterol |
| Current Past | Allergies | Current Past | HIV/AIDS |
| Current Past | Alzheimer’s Disease | Current Past | Infection: Type? |
| Current Past | Anxiety Disorder | Current Past | Lupus |
| Current Past | Arthritis: Osteoarthritis? Rheumatoid? | Current Past | Lymphedema |
| Current Past | Athletes Foot | Current Past | Mononucleosis |
| Current Past | Asthma | Current Past | Multiple Sclerosis  |
| Current Past | Blood Clot/ Deep Vein Thrombosis/  | Current Past | Muscular Dystrophy |
| Current Past | Broken or fractured bones  | Current Past | Numbness/ Tingling: Area? |
| Current Past | Bursitis | Current Past | Osteoporosis/Osteopenia |
| Current Past | Cancer: Location | Current Past | Pain? Location? |
|  |  Treatment:  |  |  Muscular or Joint? Chronic? |
|  |  In Remission Y/N | Current Past | Paralysis |
| Current Past | Carpal Tunnel Syndrome | Current Past | Phlebitis/ Embolism |
| Current Past | Cerebral Palsy | Current Past | Pregnancy |
| Current Past | Chronic Fatigue Syndrome | Current Past | Psoriasis |
| Current Past | Contagious condition | Current Past | Rash |
| Current Past | Crohn’s disease | Current Past | Sciatica |
| Current Past | Depression | Current Past | Scoliosis |
| Current Past | Diabetes Type I Type 2 | Current Past | Seizure |
| Current Past | Diverticulitis | Current Past | Sleeping problems |
| Current Past | Eczema | Current Past | Spasms/ Cramping |
| Current Past | Epilepsy | Current Past | Strain/ Sprain |
| Current Past | Fertility Concerns | Current Past | Stroke |
| Current Past | Fibromyalgia  | Current Past | Tendonitis |
| Current Past | General Fatigue  | Current Past | Thyroid issues |
| Current Past | Gout  | Current Past | TMJ/ Jaw Pain |
| Current Past | Headaches Location:  | Current Past | Tumor: Location? |
|  | Frequency? |  | Malignant or Benign? |
| Current Past | Hearing Impairment | Current Past | Varicose Veins |
| Current Past | Heart Condition | Current Past | Visually impaired |
| Current Past | Herpes/ Shingles | Current Past | Other |
| Current Past | High/ Low Blood Pressure |  |  |

**Release Form**

By signing this, I agree that I have answered all questions to the best of my knowledge and that I will inform the therapist of any changes in my condition or medication. If I experience any pain/discomfort or would like the pressure adjusted, I will inform the therapist immediately.

I understand that a massage therapist cannot diagnosis any illness, disease, or any physical or mental disorders nor can the therapist prescribe any medication and that nothing said in a session should be construed as such. I understand that massage therapy is intended to work in conjunction with my health care, not act as a substitute for medical examination. I understand that it is my responsibility to consult a physician for any ailments I may have.

I understand that massage therapy is a therapeutic measure used to reduce stress, muscular tension, and pain. I understand there are no guarantees for recovery and if I am unsatisfied with the progress made with my treatment I will inform the therapist, so he/she may direct me to another treatment

I agree to abide by a 24 hour cancellation notice for any scheduled massage. I understand I may be charged up to the full amount of service for missed appointments or for any cancellations with less than a 24 hour notice. I understand that if I arrive late for an appointment, the session will end at the original scheduled time to prevent penalizing another client. However, if the massage therapist is late, he/she will fulfill the scheduled massage length or offer a reasonable compensation.

I understand that if I use a coupon during my visit, it is not valid with any other coupons or promotions.

I agree that I am of legal age (18 years old) and that if I am not, I agree to have my parent or guardian sign a parental/guardian release form before treatment.

***I understand that certain conditions or medications may contraindicate (not permit) massage or may require the use of alternate techniques or pressure. I respect the decision of the massage therapist and am fully prepared to reschedule the massage for a later date if requested by the massage therapist. I also understand that massage may be advisable by my physician, but not by a massage therapist. In that event, I agree to provide a written agreement from my physician before proceeding with treatment.***

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Minor: Parental Consent**

Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_