Heart of Life Massage, LLC

Client Intake Form

Name _____ Phone(day) _____ Cell _____

Address _____ City/State/Zip _____

Email _____

Date of Birth _____ Referred By _____

Emergency Contact _____ Phone _____

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

Have you ever had a professional massage before? Yes No
If yes, how often? _____

Do you have difficulty lying on your front, side or back? Yes No
If yes, please explain _____

Do you have any allergies to oils, lotions, ointments, fruits or nuts? Yes No
If yes, please explain _____

Do you have sensitive skin? Yes No

Are you wearing [ ] contact lenses [ ] dentures [ ] hearing aid [ ] prosthetics

Do you sit for long hours at a workstation, computer or driving? Yes No
If yes, please describe _____

Do you perform any repetitive movement in your work, sports or hobby? Yes No
If yes, please describe _____

How do you feel stress in your work, family or other aspect of your life affected your health?
[ ] muscle tension [ ] anxiety [ ] insomnia [ ] irritability [ ] other

Is there a specific area of your body where you are experiencing tension, stiffness, pain or discomfort?
Yes No If yes, please identify _____

Do you have any particular goals in mind for this massage session? Yes No
If yes, please explain _____

Medical History

Do you currently or have you ever had any of the following? (please check)

[ ] phlebitis	[ ] tennis elbow
[ ] deep vein thrombosis/ blood clots	[ ] recent fracture
[ ] joint disorder	[ ] artificial joint
[ ] rheumatoid arthritis/ osteoarthritis/ tendinitis	[ ] sprains/ strains
[ ] osteoporosis	[ ] current fever
[ ] epilepsy	[ ] swollen glands
[ ] headaches/ migraines	[ ] allergies/sensitivity
[ ] cancer	[ ] heart condition
[ ] diabetes	[ ] high or low blood pressure
[ ] decreased sensation	[ ] circulatory disorder
[ ] back/neck problems	[ ] varicose veins
[ ] fibromyalgia	[ ] atherosclerosis
[ ] TMJ	[ ] easy bruising
[ ] carpal tunnel syndrome	[ ] recent accident or injury
[ ] contagious skin condition	[ ] pregnancy if yes, how many months?

Are you currently under medical supervision? Yes No
If yes, please explain _____

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

Are you currently taking any medications? Yes No
If yes, please list _____

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

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my massage session, I will immediately inform the therapist so that the pressure 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 or other qualified medical specialist for any 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.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____