JANICE MASON, LMT, NASM-PT, CES
INTUITive Kinetics Massage Therapy PC

Massage Client Intake Form

Personal Information

Name: _____ Date of Birth:_____

Address:_____ City/State/Zip: _____

Phone:_____ Email:_____

Occupation: _____ Emergency Contact Phone: _____

The following information will be used to help plan safe and effective massage sessions.
Have you ever received massage therapy? ☐Yes ☐No If yes, how often? _____

Type(s) of massage received: _____

Are you currently taking any medications? ☐Yes ☐No If yes, please list name and reason for medications:

_____

Are you currently seeing healthcare professional? ☐Yes ☐No
If yes, please list reason/treatment:_____

_____

Exercise routine, if any: _____

Please review this list and check those conditions that have affected your health either recently or in the past:

- ☐ Arthritis
- ☐ Diabetes
- ☐ Blood clots
- ☐ Broken/dislocated bones
- ☐ Bruise easily
- ☐ Cancer
- ☐ Chronic pain
- ☐ Constipation/diarrhea
- ☐ Auto-immune condition
- ☐ Hepatitis (A, B, C other)
- ☐ Skin conditions
- ☐ Stroke
- ☐ Recent surgery
- ☐ TMJ disorder/jaw pain
- ☐ Anemia
- ☐ Herniated disks
- ☐ Neurological problems
- ☐ Depression, panic disorder, other psych condition
- ☐ Ulcers
- ☐ Varicose veins
- ☐ Headaches
- ☐ Heart conditions
- ☐ Back problems
- ☐ High blood pressure
- ☐ Insomnia
- ☐ Muscle strain/pain
- ☐ Currently pregnant
- ☐ Scoliosis
- ☐ Seizures
- ☐ Whiplash/recent car accident
- ☐ Chemical dependency (alcohol, drugs)
- ☐ Respiratory problems
- ☐ Fainting spells/dizziness
- ☐ Muscle cramping

If you have any other medical condition(s) that we should be aware of or you need to elaborate on a condition you checked above, please tell us here:

_____

_____

Do you have any of the following today:

☐ Skin rash ☐ Cold/flu ☐ Open cuts
☐ Anything contagious ☐ Severe pain ☐ Injuries/bruises

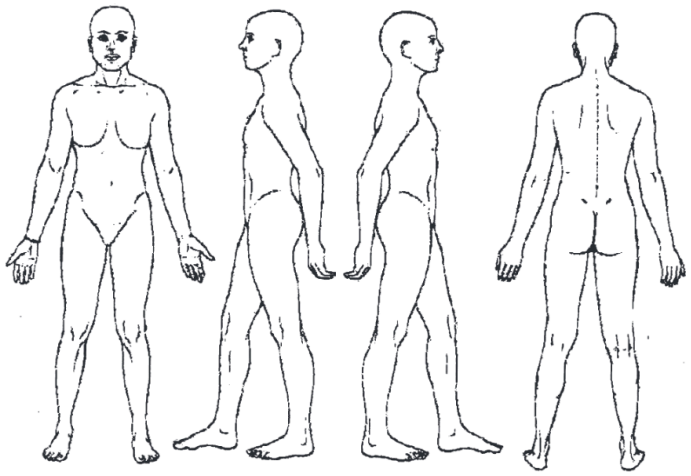
Do you have any allergies to:

☐ Environmental allergens (dust, pollen, fragrances) ☐ Medications
☐ Reactions to skin products ☐Food (nuts, etc.)

If any of the above are checked, please give details: _____

Are you wearing: ☐ Contact lenses ☐ Hearing aid ☐ Hairpiece

Please mark and label the diagram with aches, pains, numbness, or other problems:



X —Stabbing pain
O —Numbness
/// —Aches
+++ —Pins & needles
*** —Burning

What are your goals/expectations for this therapy session: _____

_____

While you are relaxing and relating, most times things are releasing. This is quite normal and expected: Stomach gurgling, possible flatulation, moaning, expressions of relief or "hitting the right spot," emotional talking or falling asleep. Trust that whatever happens, you're in a no-judgment zone.

Please read the following information and sign below:
Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

1). I, (print name clearly) _____ understand that massage can be very relaxing and therapeutic in relieving muscular tension. The massage therapist is not qualified and cannot substitute it for a physical or mental medical examination, diagnosis or treatment and nothing in the course of the session should be construed as such.
2). This is a therapeutic massage and any sexual remarks or advances will terminate the session and the client will be liable for full payment of the scheduled treatment.
3). Because massage should not be performed under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: _____ Date: _____

Your health information will be kept strictly confidential. Any information that I collect about you on this form will be kept confidential in my office.