

Massage Therapy Intake Form

Name _____ Date ____/____/____

DOB ____/____/____ E-mail address* _____@_____.com

*Email address will be used to remind you of your appointment and send you promotions. Please notify us if you would like to be excluded.

<p>I like to send birthday, Christmas and thank you cards. If you like to receive them, please give me your address: Address _____ City/State _____ Zip _____</p>	<p>Have you ever experienced a professional massage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are there any techniques that you liked/disliked? _____ _____</p>
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Please initial to consent to the following modalities.

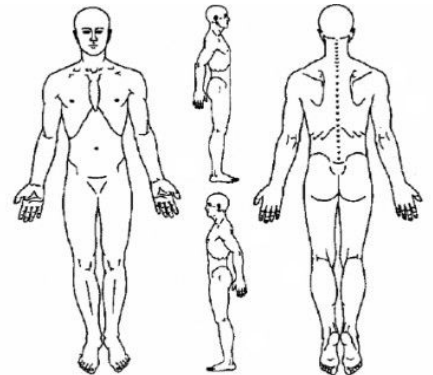
<p>Cupping ___ Yes ___ No</p> <p>Suction using cups improves circulation, breaks up connective tissue, and helps with lymphatic drainage. Light bruising, cupping marks, and redness may be a side effect of this modality. This is normal and should dissipate within a few days.</p>	<p>Heat ___ Yes ___ No</p> <p>Hot stones, warm towels, warm bamboo, and other techniques may be used in your massage. Heat assists with muscle relaxation and improves circulation.</p>	<p>Aromatherapy ___ Yes ___ No</p> <p>Aromatherapy can be used to increase relaxation, help the healing process, clear sinuses and more during a massage.</p>	<p>Allergies ___ Yes ___ No</p> <p>Do you have any sensitivities or allergies to oils, lotions, scents, heat, cold or foods? If yes, please list _____ _____</p>
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What kind of pressure do you prefer? **Light Medium Firm Deep**

On the picture to the right, please **CIRCLE** any areas that you are having **pain, stiffness, or tightness.**

Please put an X on any areas that you would like for me to avoid.

Pregnant / Nursing / Surgeries / Injuries / etc.? _____



 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 the 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. 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 massage therapist updated** as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapist's part should I fail to do so.

I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the License Massage Therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated. Please notify your massage therapist if you have any questions or concerns.

Signed _____ **Date** _____