Massage by Rosie

Massage Intake Form

Client Information

Date: _____

Name: _____ DOB: _____ Gender ☐ Male ☐ Female

Cell Phone: _____ Text OK? ☐ Yes ☐ No

How do you prefer to be contacted? _____

Email: _____

Address: _____ City: _____ ST: _____ Zip: _____

Occupation: _____

Emergency Contact: _____ Emerg. Cont. Phone: _____

How Did You Hear About Us? _____

Have you ever had professional massage before? ☐ Yes ☐ No if yes, when? _____

Medical Background

Are you currently under the care of a physician? ☐ Yes ☐ No if yes, for what condition? _____

Previous surgeries/injuries/accident/illness and dates: _____

_____

Do you have any contagious disease? ☐ Yes ☐ No if yes, for what disease? _____

Do you suffer from frequent headaches? ☐ Yes ☐ No if yes, how often? _____

Please list any medications you are taking and why: _____

Are you Pregnant? ☐ Yes ☐ No If yes, when are you due? _____

Client Self Assessment

Please check any condition listed below that applies to you:

- ☐ Arthritis
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Joint Swelling
- ☐ Open Sores
- ☐ Cardiac Problems
- ☐ Kidney Disease
- ☐ Varicose Veins
- ☐ Osteoporosis
- ☐ Allergic to nuts
- ☐ Allergic to oils
- ☐ Other Allergies _____
- ☐ Cancer
- ☐ Circulatory Problems
- ☐ Tennis Elbow
- ☐ Numbness
- ☐ Stabbing Pain
- ☐ Broken Bones
- ☐ Recent Surgery
- ☐ Sprains/Strains
- ☐ TMJ Problems

Comments: _____

_____

Do you smoke? ☐ Yes ☐ No

How often do you exercise? _____

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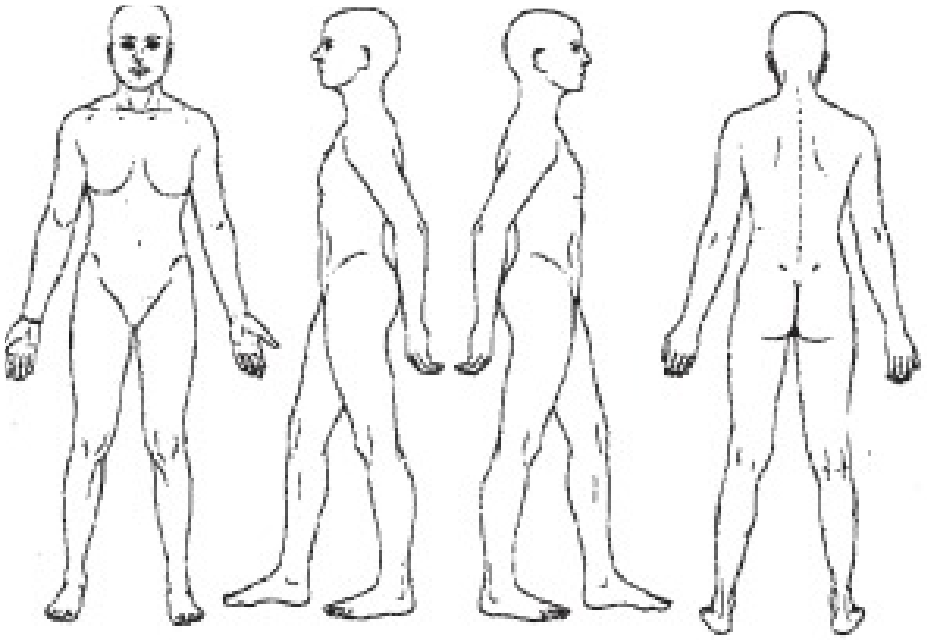
What is your reason(s) for your massage today?

☐ Relaxation ☐ Release Tension ☐ Aid in Recovery from an Injury ☐ Other _____

Please indicate with a circle any areas you are feeling discomfort.



Comments: _____

_____

_____

Informed Consent to Treatment

- I have completed this form to the best of my knowledge and will inform the massage therapist of any change in my physical health.
- I understand that a massage therapist can not diagnose illness, disease, or any other medical, physical, or emotional disorder nor perform any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailments that I have.
- I understand that massage therapy is a therapeutic health aide and is non-sexual. I also understand that any illicit or sexually suggestive remarks or advances made will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.
- I understand that if the massage therapist starts a session late, she will make it up to me at the end of my session if possible, or will reduce my fee accordingly. I understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized and full payment will be due.
- I agree to give 24-hour notice for a scheduled session that I cannot keep. I am aware that I may be charged the full fee for any missed sessions or for sessions that I do not give 24-hour notice to cancel or reschedule.

Signed: _____ Date: _____