CLIENT INTAKE FORM

Name: **E-mail:**

Address: **Date of birth: / /**

City/State/Zip: **Phone: ( ) -**

***** *Best way for appointment reminders:* ***E-mail, Text,*** *or* ***Phone?***

Occupation/Employer:_____
Emergency Contact Name: _____ Phone: (_____)_____-_____

Have you ever had a professional massage before? **YES/NO**

If Yes, How Often? _____

Desired Pressure:* **LIGHT/MEDIUM/FIRM

What is your goal for today's session?
_____

Any areas that you would ***LIKE*** concentrated on?

Face	**Scalp**	**Neck**
Upper Chest	**Shoulders**	**Stomach**
Upper Back	**Mid Back**	**Low back**
Arms	**Hands**	**Gluteals**
Legs	**Feet**	

Any areas that you would ***NOT LIKE*** touched?

Face	**Scalp**	**Neck**
Upper Chest	**Shoulders**	**Stomach**
Upper Back	**Mid Back**	**Low back**
Arms	**Hands**	**Gluteals**
Legs	**Feet**	

MEDICAL INFORMATION

Are you currently under a doctor's care or medical supervision of any kind? **YES/NO**

What medications are you taking (including Aspirin and over the counter)? _____

In the last 3 years, have you had any serious injuries or surgeries? **YES/NO**
If yes, please explain:
_____

Currently are you experiencing any: **pain, tenderness, numbness, tingling, allergies, stress, stiffness, or swelling?**

Are you wearing any of the following: **Contact lenses, dentures, hearing aid, hairpiece/wig, piercing, or N/A**

Do you have any of these medical devices? **Insulin pump, pacemaker, temporary IV, bone pin, spinal rod, or N/A**

Are there any medical conditions you are currently dealing with? **YES/NO**
Examples: *Blood conditions, Immune system conditions, Respiratory conditions, bone or joint issues, chronic pain, cancer (currently), viral infections, headaches, skin issues, cuts/or abrasions, or pregnancy?*
If Pregnant, How many weeks? _____

INFORMED CONSENT

I, _____, (client) understand that massage therapy provided by, ***Savanna McGlone, LMT*** is intended to enhance relaxation, reduce pain caused by muscle tension, increased range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes for massage therapy are specified in space below:

The general benefits of massage, possible massage contraindication and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Care giver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

Because massage/bodywork should not be performed under certain medical conditions: I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment for the full time scheduled.

If I experience any pain or discomfort during the session, I will immediately communicate that to the therapist so the treatment can be adjusted.

Client Signature: X _____ Date: _____