

Massage Kneaded - Client Health Intake Form

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip code _____ Occupation _____

E-mail _____

Home Phone# _____ Cell Phone# _____

Emergency contact person & Phone# _____

How did you hear about us? _____ We reward **REFERRALS**.

Do you have or have you had a history of the following?

Are you Pregnant?Y/N	ThrombophlebitisY/N	Skeletal Disorders.....Y/N
Do you Smoke?Y/N	Nervous DisorderY/N	Herniated Disc.....Y/N
Wear contacts?Y/N	SurgeryY/N	Sciatica.....Y/N
CancerY/N	Skin Diseases/RashY/N	Neck Pain.....Y/N
Heart DisordersY/N	Digestive DisordersY/N	Back Pain.....Y/N
High Blood PressureY/N	ConstipationY/N	Back Surgery.....Y/N
Circulatory ProblemsY/N	Migraine HeadachesY/N	Athletes Foot/Fungus...Y/N
DiabetesY/N	InsomniaY/N	Exercise Program.....Y/N
Varicose VeinsY/N	ArthritisY/N	

If you have answered yes to any of the above, please describe _____

List all other medical conditions or injuries that you have? _____

List all current medications _____

Can Massage Kneaded consult your healthcare providers about your care? Y / N

Attending Physician _____ Phone# _____

Have you had a professional massage before? Y / N Massage pressure you like? Light /Medium/ Deep

Primary reason for receiving this massage _____

What specific areas would you like us to focus on? _____

Any specific area(s) you would like us to avoid? _____

I understand that massage therapy given here is for the purpose of stress reduction, relief for muscular tension or spasm, or for increased circulation and energy flow. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and/or diagnosis, and that it is recommended that I see a physician for any ailment that I might have.

Because a massage therapist must be aware of existing medical conditions,
I have stated all my known medical limitations and take it upon myself to keep the massage therapist updated on my physical health.

Any sexual misconduct will not be tolerated.

Sexual misconduct will result in the immediate stoppage and full payment of the session price will be due.
In addition, legal charges may be filed with the courts.

I agree to pay for massage therapy rendered and sessions missed when I do not give at least 24 hours cancellation notice.

Sign Name _____ Date _____