Blaine Healing Arts Massage Therapy
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Client Intake Form – Therapeutic Massage

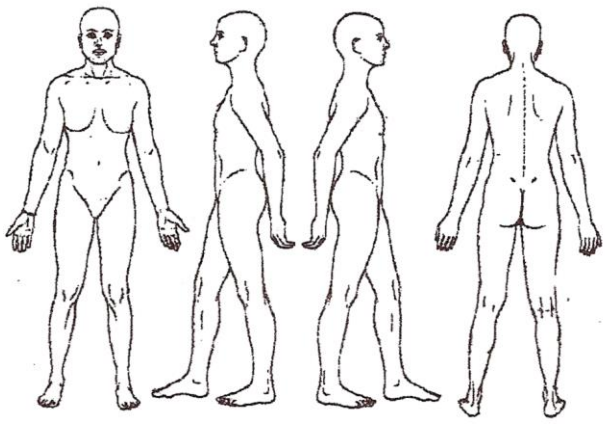
Personal Information:

Name: _____ Date:_____
Address:_____
City/State/Zip: _____
Phone: Cell _____ Home _____
Date of Birth: _____Occupation_____
Emergency Contact _____ Phone _____
Email _____Do you want to receive our e-mail newsletter? YES NO
How did you hear about us? Google Website Facebook Newspaper Ad Street Signs
Phone Book Friend Other:_____

The following information will be used to help plan a safe and effective massage sessions. Please answer the questions to the best of your knowledge.

1. Have you had a professional massage before? **Yes** **No** If yes, how often? _____
2. Do you have any difficulty lying on your front, back, or side? **Yes** **No**
   If yes, please explain: _____
3. Do you have any allergies? **Yes** **No**
   If yes, please explain: _____
4. Do you have sensitive skin? **Yes** **No**
5. Do you sit for long hours at a workstation, computer, or driving? **Yes** **No**
   If yes, please describe: _____
6. Do you perform any repetitive movement in your work, sports, or hobby? **Yes** **No**
   If yes, please describe: _____
7. Do you experience stress in your work, family, or other aspect of your life? **Yes** **No**
   If yes, how do you think it has affected your health? muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other _____
8. Is there a particular area of the body where you are experiencing tension, stiffness, pain
   If yes, please identify: _____
9. Is there an area of the body you prefer not to be touched (i.e. feet, ears, face, etc):_____
10. Do you have any particular goals in mind for this massage session?
    If yes, please explain: _____

Circle any specific areas you would like the massage therapist to concentrate on during the session:



Continue on Back

Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

11. Are you currently under medical supervision? **Yes** **No** Doctor's Name: _____
12. Do you see a chiropractor? **Yes** **No** Chiropractor's Name: _____
13. Are you currently taking any medication? **Yes** **No**

    If yes, please list _____ ____
14. Please check any condition listed below that applies to you:

( ) contagious skin condition	( ) phlebitis
( ) open sores or wounds	( ) deep vein thrombosis/blood clots
( ) easy bruising	( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) recent accident or injury	( ) osteoporosis
( ) recent fracture (last 2 years)	( ) epilepsy
( ) recent surgery	( ) headaches/migraines
( ) artificial joint	( ) cancer
( ) sprains/strains	( ) diabetes
( ) current fever	( ) decreased sensation
( ) swollen glands	( ) back/neck problems
( ) allergies/sensitivity	( ) Fibromyalgia
( ) heart condition	( ) TMJ
( ) high or low blood pressure	( ) carpal tunnel syndrome
( ) circulatory disorder	( ) tennis elbow
( ) varicose veins	( ) pregnancy If yes, how many months? _____
( ) atherosclerosis	( ) gout

Other_____

Please explain any condition that you have marked above _____

_____

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

_____

Draping will be used during the session - only the area being worked on will be uncovered.

Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 18.

I, _____(print name) 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 this 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 and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

____ (initial) I have read the policies and procedures and agree to abide by them.

Signature _____ ***Date***_____