MASSAGE INTAKE FORM - CONFIDENTIAL INFORMATION

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Name _____ Date of birth _____

Address _____ City _____

State _____ Zip _____ Email _____

Phone _____ Occupation _____

Have you ever received massage therapy? ____Yes* ____No *If yes, how often? _____

Type(s) of massage experienced _____

Are you currently taking any medications? ____Yes ____No

If yes, please list name and reason for medications _____

Are you currently seeing a healthcare professional? ____Yes ____No

If yes, please list reason/treatment _____

Exercise routine, if any? _____

Please review this list and check those conditions that have affected your health either recently or in the past.

__ arthritis
__ diabetes
__ blood clots
__ broken/dislocated bones
__ bruise easily
__ cancer
__ chronic pain
__ constipation/diarrhea
__ auto-immune condition
__ hepatitis (A, B, C, other)
__ skin conditions
__ stroke
__ recent surgery
__ TMJ disorder/jaw pain
__ anemia
__ herniated disks
__ neurological problems
__ depression, panic disorder, other psych condition
__ ulcers
__ varicose veins
__ headaches
__ heart conditions
__ back problems
__ high blood pressure
__ insomnia
__ muscle strain/sprain
__ currently pregnant
__ scoliosis
__ seizures
__ whiplash/recent car accident
__ chemical dependency (alcohol, drugs)
__ respiratory problems
__ fainting spells/dizziness
__ muscle cramping

If you have any other medical condition that we should be aware of or you need to elaborate on a condition you checked above, please tell us here:

_____

_____

Do you have any of the following today:

___ skin rash ___ cold/flu ___ open cuts

___ anything contagious ___ severe pain ___ injuries/bruises

Do you have any allergies to:

___ environmental allergens (dust, pollen, fragrances) ___ medications

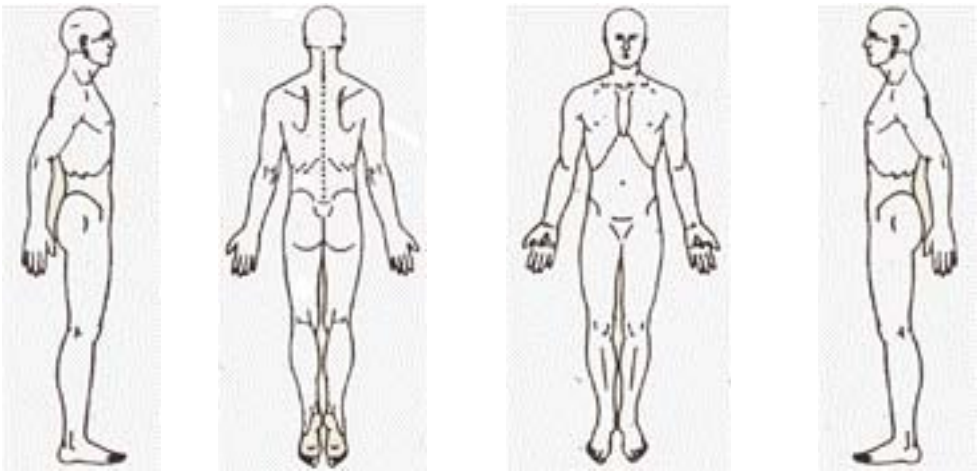
___ reactions to skin care products ___ foods (nuts, etc.)

If any of the above are checked, please give details: _____

_____

Are you wearing: ___ contact lenses ___ hearing aid ___ hairpiece

Please mark and label the diagram with aches, pains, numbness, or other problems.



X – Stabbing Pain
O – Numbness
//// – Aches
+++ – Pins and Needles
---- – Burning

What are your goals/expectations for this therapy session? _____

_____

_____

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to:
moving or changing position * sighing, yawning, change in breathing * stomach gurgling
emotional feelings and/or expression * memories * energy shifts * falling asleep

Understandings and Agreements

Understandings:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.

2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.

3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Agreements:

New York State mandates that records accurately reflecting your evaluation and treatment be created and maintained and be available to you. Unless you check the box below, you are requesting and **agreeing** that these records be kept at Melt Massage's facility at 84 Lafayette Avenue, Brooklyn, New York.

□ No, I want my records maintained at: _____.

Unless you have checked the box below, you are requesting and **agreeing** that the massage therapy services be provided to you at Melt Massage's facility at 84 Lafayette Avenue, Brooklyn, New York.

□ No, I want my massage therapy services rendered at a different suitable location: _____.

Client Signature: _____ Date: _____