Client Intake Form – Therapeutic Massage

Personal Information:

Name: _____ Phone (Day): _____ Phone (Eve): _____

Address: _____

City/State/Zip: _____

Email: _____ Date of Birth: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

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

Date of Initial Visit: _____

1. Have you had a professional massage before? ☐ Yes ☐ No
   If yes, how often do you receive massage therapy? _____

2. Do you have any difficulty lying in any position? ☐ Yes ☐ No
   If yes, please explain: _____

3. Do you have any sensitivities to scents, fragrances or specific products? ☐ Yes ☐ No
   If yes, please explain: _____

4. Do you bruise easily? ☐ Yes ☐ No

5. Are you wearing ☐ contact lenses ☐ dentures ☐ a hearing aid?

6. Do you sit for long hours at a workstation, computer, or driving? ☐ Yes ☐ No
   If yes, please describe: _____

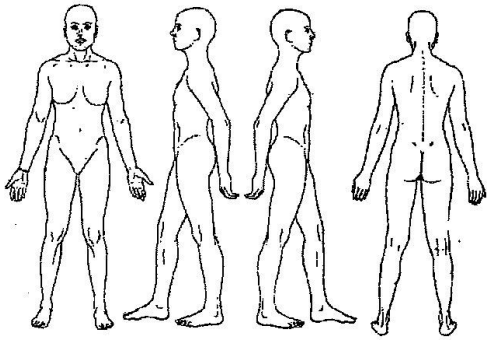
7. Do you perform any repetitive movement in your work, sports, or hobby? ☐ Yes ☐ No
   If yes, please describe: _____

8. 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

9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? ☐ Yes ☐ No
   If yes, please identify: _____

10. Do you have any particular goals in mind for this massage session? ☐ Yes ☐ No
    If yes, please explain: _____

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



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Arrowhead Physical Therapy

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
    If yes, please explain: _____

12. Do you see a chiropractor? ☐ Yes ☐ No
    If yes, how often? _____

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

Please explain any condition that you have marked above: _____

_____

15. Are there any other concerns? _____

_____

Draping will be used during the session – only the area being worked on will be uncovered. Clients under the age of 17 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 17.

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.

Signature of client: _____ Date: _____

Signature of Massage Therapist: _____ Date: _____

Arrowhead Physical Therapy

Massage Cancellation Policy:

Unfortunately, life sometimes gets in the way of keeping an appointment. If you need to cancel your massage appointment and you wish not to be billed for the appointment, you must notify us within 24 hours of your appointment time. If less than a 24 hour notice is provided, you will be billed for 50% of your massage fee. Clients who do not show up for their appointment and do not notify us in advance will be billed the full massage fee. Emergency cancellations are determined at the practitioner's discretion.

Massage Termination:

Massage services will be terminated immediately if a client makes any sexual advances or requests. Even questionable sexual discussion may be cause for termination. Massage therapy is therapeutic in nature and any interactions and communications must remain professional. If the massage is terminated for the above mentioned reasons, payment is still required.

A session will not be conducted if the client is intoxicated, using drugs, or threatening the safety of the massage therapist, the safety of others in the building, or themselves.

Massage Guidelines:

1. Sessions are intended to begin and end at the scheduled times. Sessions that begin late due to the client's late arrival will end at the scheduled time and will be billed at the full rate.
2. If a client has a cold, flu, sore throat, stomach virus, poison ivy, skin rash, or any other contagious condition, we ask that you please reschedule your appointment.
3. Clients must be present and not under the influence of alcohol or drugs.
4. Clients must provide a health history and related health update, as deemed necessary.
5. Sexual harassment is not tolerated and the session will be terminated if this occurs or if the practitioner's safety is compromised in any way.
6. This office is a non-smoking, odor-neutral environment.
7. Clients are expected to be clean, having showered the same day as the massage.
8. Clients are asked not to eat a heavy meal less than two hours prior to the massage.

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Client Expectations:

1. We provide our clients with a competent and professional session which is customized and focuses on the individual needs of each client.
2. Clients are draped with a sheet at all times during the session. Only the parts of the body being worked on are exposed at any time. The genital area is never exposed or massaged.
3. Clients are treated with respect and dignity.
4. Personal and professional boundaries are respected at all times.
5. We treat all clients equally regardless of their age, gender, race national origin, sexual orientation, religion, socio-economic status, body type, and political affiliation, state of health or personal habits.
6. Privacy and confidentiality are maintained at all times.
7. We take pride in staying current with massage techniques and are committed to providing "state-of-the-art" bodywork.
8. The massage therapist performs services which he/she is able and qualified, both physically and emotionally, to perform.
9. Appointments are confirmed the day prior to the scheduled appointment and insurance billing is not provided.
10. The massage therapist will refer our clients to an appropriate specialist when the treatment is not within the scope of the massage.
11. Accurate records are maintained and client charts are reviewed before each massage session.
12. Equipment and supplies are kept clean and safe.

Client Acknowledgment

I have read, fully understand and will abide by the massage policies and guidelines included herein.

_____
Client Printed Name

_____ _____
Client Signature Date

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