

A Calmness Within Massage Therapy

Client Health Intake Form

Please fill out form completely and sign second page

Client Name _____ Date: _____
Address _____ Zip Code: _____
Email: _____ Birth Date: _____

Preferred Phone Number/s: _____
Occupation: _____ Referred By: _____

Have you ever received a professional massage? Yes No

Current Health:

Where are you feeling pain, tension, numbness, tingling? _____

Do you have limited range of motion? Where? _____

Do you have any allergies/sensitivities to: oils lotions scents foods

Please describe: _____

Do you wear contact lenses? Yes No

What exercise do you regularly perform? _____

Medical History:

Are you presently under a doctor's or therapist's care? Yes No

If so, for what? _____

Are you pregnant? No Yes If yes, what week? _____ (also fill out pregnancy intake)

Please describe any injuries or surgeries in the past 5 years: _____

Please check any of the following conditions you have now or had in the past:

- | | | |
|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Osteoporosis/osteopenia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Heart disease/attack | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Broken/fractured bones | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Skin disorders |
| <input type="checkbox"/> Cancer (primary site): _____ | <input type="checkbox"/> Jaw pain (TMJ) | <input type="checkbox"/> Slipped/degenerative/fused disc |
| <i>also fill out oncology intake</i> | <input type="checkbox"/> Lymph node removal (specify location): _____ | <input type="checkbox"/> Tendon/ligament/cartilage tear |
| <input type="checkbox"/> Diabetes | _____ | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Edema (swelling) | <input type="checkbox"/> Numbness | <input type="checkbox"/> Other, please specify: _____ |
| | <input type="checkbox"/> Osteoarthritis | _____ |

Are you taking any of the following medication?

- | | |
|--|--|
| <input type="checkbox"/> Blood pressure medication | <input type="checkbox"/> Cortisone injection |
| <input type="checkbox"/> Blood thinner | <input type="checkbox"/> Anti-inflammatories |
| <input type="checkbox"/> Pain killers | <input type="checkbox"/> Muscle relaxants |

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CANCELLATION POLICY:

Our time together is important. Unless you have an emergency, please give 24-hours advanced notice to cancel appointments or you will be charged for full payment of missed sessions.

Our goal at A Calmness Within is to create a soothing and welcoming therapeutic environment and to provide an outstanding massage experience to our clients. All discussion and work between us will remain confidential. As a valued client of A Calmness Within Massage Therapy we want you to feel safe and well taken care of; communication, respect and trust are important to have a successful session together.

Massage therapy is meant to move fluids and energy throughout the body; it can have many benefits including easing muscle tension and pain, promoting relaxation, and reducing stress. Massage is not a substitute for medical advice. We will not diagnose, prescribe drugs, or give advice to clients regarding their medical conditions. A Calmness Within Massage Therapy is strictly non-sexual. Inappropriate behavior is grounds for immediate termination of session.

I acknowledge that all of the information on this form is complete and accurate. By signing this release I hereby waive and release A Calmness Within Massage Therapy and its practitioners from all liability. I understand the therapist may make notes in the Therapist's Notes section below.

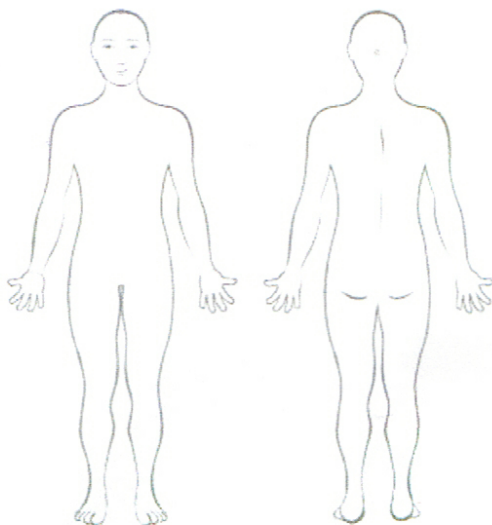
Signature: _____

Date: _____

CLIENT'S DO NOT WRITE BELOW THIS LINE

Therapist's Notes: _____

Therapist Signature: _____



S _____

O _____

A _____

P _____
