



## 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 \_\_\_\_\_  
State \_\_\_\_\_ City \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Occupation \_\_\_\_\_  
Email \_\_\_\_\_

Have you ever received massage therapy? \_\_\_\_\_ Yes \_\_\_\_\_ No

Type of massage experienced (Swedish, shiatsu, deep tissue, etc.) \_\_\_\_\_

Do you have any sensitivity to heat or cold? (ie hot pack, ice packs, biofreeze) \_\_\_\_\_

What massage pressure do you prefer? \_\_\_\_\_ light \_\_\_\_\_ med \_\_\_\_\_ firm \_\_\_\_\_ deep

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 names and reason/treatment \_\_\_\_\_

### Accommodations

Do you have difficulty lying on your front, back, or side? Yes ( ) No ( )

Describe \_\_\_\_\_

Do you wear any of the following? (check all that apply)

( ) Contact lenses ( ) Glasses ( ) Hearing Aid ( ) Dentures ( ) Braces ( ) Other: \_\_\_\_\_

Are you allergic to any oils/lotions? Yes ( ) No ( ) Describe \_\_\_\_\_

Are there any other special considerations you would like your therapist to know about? \_\_\_\_\_

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

- |  |  |
|--|--|
| <input type="checkbox"/> arthritis               | <input type="checkbox"/> auto-immune condition*          |
| <input type="checkbox"/> diabetes                | <input type="checkbox"/> hepatitis (A, B, C, other)      |
| <input type="checkbox"/> blood clots             | <input type="checkbox"/> skin conditions (explain below) |
| <input type="checkbox"/> broken/dislocated bones | <input type="checkbox"/> stroke                          |
| <input type="checkbox"/> bruise easily           | <input type="checkbox"/> surgery (explain below)         |
| <input type="checkbox"/> cancer (explain below)  | <input type="checkbox"/> TMJ disorder                    |
| <input type="checkbox"/> chronic pain            | (*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)      |
| <input type="checkbox"/> constipation/diarrhea   |  |

- depression, panic disorder
- other psychological condition
- diverticulitis
- headaches
- heart conditions
- back problems
- high blood pressure

- insomnia
- muscle strain/sprain
- pregnancy (\_\_\_\_\_ weeks along)
- scoliosis
- seizures
- whiplash
- chemical dependency (alcohol, drugs)

Additional Information: \_\_\_\_\_

Do you have any of the following today:

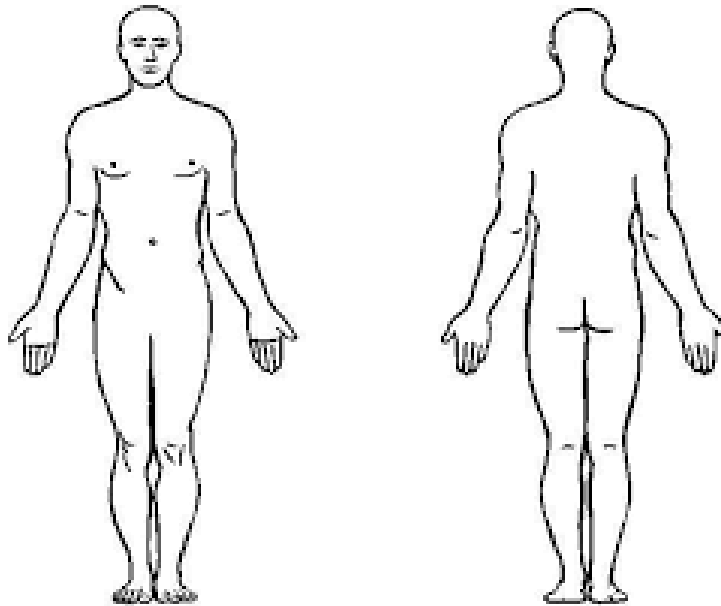
- skin rash    open cuts    severe pain    sickness    injuries/bruises

Do you have any allergies to:

- medications    foods    environmental allergens    reactions to skin care products

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

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



What are your goals/expectations for this therapy session? \_\_\_\_\_

What are your long-term goals/expectations for therapy sessions? \_\_\_\_\_

## **Client Agreement**

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that Ultimate Health Medical Clinic has provided this form as a reference and is not held liable for any services provided.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## **Release of Medical Records**

I authorize the release of medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys, healthcare providers, and insurance case managers, for the purposes of processing my claims.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of parent or legal guardian (if client is a minor)** \_\_\_\_\_

(Please inform your practitioner immediately upon signing any exclusive Release of Medical Records with your attorney that may impact the above release statement )

## **Contract for Care**

I will participate fully as a member of my healthcare team. I will make sound choices regarding my sessions' plan based upon the information provided by my massage therapist. I agree to participate in my own self-care programs and adhere to the plan we select. I agree to communicate with my practitioner any time I feel my well-being is being compromised. I expect my practitioner to provide safe and effective treatment to the best of his or her skills and knowledge. I authorize and direct payment of medical benefits to my massage therapist, for services billed.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of parent or legal guardian (if client is a minor)** \_\_\_\_\_

**Please read the following information and sign below**

1. 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.
2. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

**Cancellation Policy**

1. You may cancel or reschedule without a charge any time 24 hours or more prior to your appointment.  
Initials: \_\_\_\_\_
2. If you are more than 10 minutes late for your appointment, you may receive a partial massage at the discretion of the massage therapist.  
Initials: \_\_\_\_\_
3. If you do not call to cancel/reschedule or you do not show up for your scheduled massage prior to 24 hours before your appointment, you will be charged a 50% cancellation fee to the card below.  
Initials: \_\_\_\_\_
4. After two times of cancelling within the 24-hour period or no showing your massage appointments, you will be required to pay the full price of your massage upon scheduling your future appointment(s).  
Initials: \_\_\_\_\_

Name: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Expiration: \_\_\_\_\_ CVV Security Code: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(By signing this document, you agree to the Cancellation Policy listed above.)