ULTIMATE HEALTH

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.)_____
Conversation preference: ____ none ____ light conversation ____only if initiated by patient
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_____
_____
_____
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.

____arthritis
____diabetes
____blood clots
____broken/dislocated bones
____bruise easily
____cancer (explain below)
____chronic pain
____constipation/diarrhea
____auto-immune condition*
____hepatitis (A, B, C, other)
____skin conditions (explain below)
____stroke
____surgery (explain below)
____TMJ disorder
(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

___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 ___ anything contagious ___ injuries/bruises

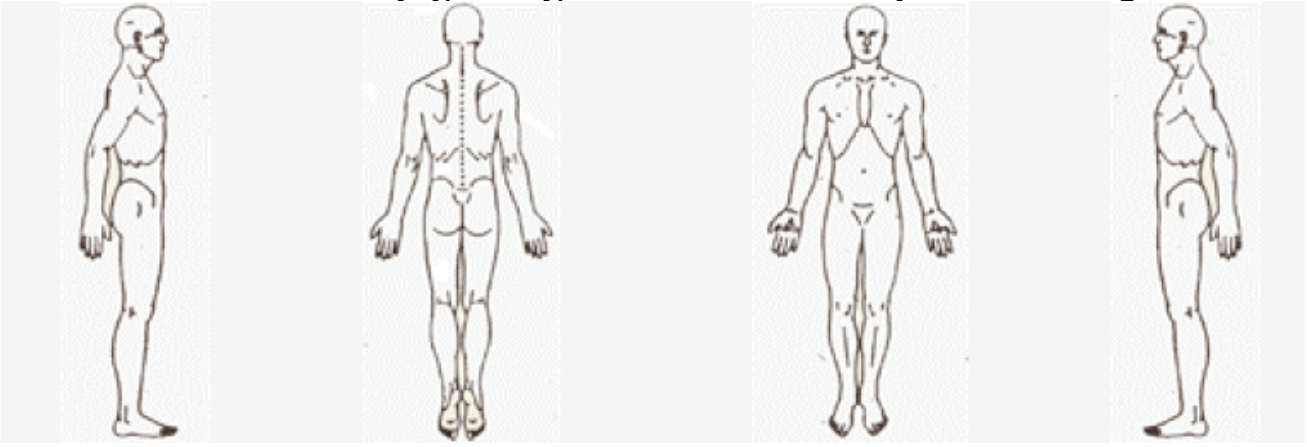
Do you have any allergies to:
___ medications ___ foods ___ environmental allergens ___ reactions to skin care products

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?
_____

_____

_____

The following sometimes occurs during massage, they are normal responses to relaxation.

- **the need to move or change position**
- **falling asleep**
- **stomach gurgling/ intestinal gas**
- **sighing, yawning, change in breathing expression**
- **energy shifts**
- **emotional feelings and/or expression**

<u>Please read the following information and sign below:</u>

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.

Cancellation Policy

1. You may cancel without a charge any time 24 hours or more prior to your appointment. Initials:_____

2. If you do not call to cancel you're appointment or you do not show up for your scheduled massage, you will be charged 50% of the total cost of your services. Initials:_____

3. 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:_____

Signature:_____
Date:_____