THERAPEUTIC MASSAGE – CLIENT INTAKE FORM

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (Day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone (Eve)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
1. Has your child had a professional massage before? Yes No

2. Does your child have any allergies to oils, lotions, or ointments? Yes No If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. List current medications and reason for taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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4. Check all the following that apply to your child:

( ) contagious skin condition ( ) open sores or wounds ( ) easy bruising   
( ) artificial joint ( ) allergies/sensitivity ( ) heart condition   
( ) high or low blood pressure ( ) circulatory disorder ( ) atherosclerosis   
( ) deep vein thrombosis/blood clots ( ) epilepsy ( ) osteoporosis   
( ) headaches/migraines ( ) cancer ( ) diabetes   
( ) fibromyalgia

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 or have informed written consent provided by parent or legal guardian prior to first session.   
I understand that the massage my child will receive is provided for the basic purpose of relaxation and relief of muscular tension. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should seek a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of my child 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 known medical conditions for my child, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my child’s medical profile and understand that there shall be no liability on the therapist’s part should I fail to do so.

I have been provided the Office Policies and understand that I have the right to request a copy.

Print Name of patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_