# *Precision Clinical Bodywork*

## Massage Intake and Consent Form

Name _____Date _____
Street Address _____
City/State/Zip _____ Gender _____
Phone Number (_____) _____-_____ Date of Birth _____
Email Address _____
Occupation _____ Emergency # _____

How were you referred to the practice? _____
Areas of pain or tension: _____
Areas to avoid: _____
Areas of limited movement: _____
Areas sensitive to pressure: _____
Are you allergic to anything: _____
Goals _____
What kind of pressure do you prefer? ___ Gentle, non-invasive ___ Therapeutic, but comfortable ___ Very firm

### HEALTH AND MEDICAL INFORMATION

(Please answer the following to the best of your knowledge.)

Are you currently under the care of a physician? ___ Yes ___ No
Are you currently taking any medications? ___ Yes ___ No
If yes, please list: _____
Have you sustained any serious injuries? ___ Yes ___ No
If yes, please list: _____
Have you had any major surgical operations? ___ Yes ___ No
If yes, please list: _____
Have you had any injections within the last 30 days? ___ Yes ___ No
If yes, please list: _____
Type of Exercise/Frequency: _____

Have you been diagnosed with any of the following conditions?

| | | |
|---|---|---|
| Headaches/Migraines | Asthma | Plantar Fasciitis |
| Arthritis | Osteoporosis | Sciatica |
| Back Pain | HIV/AIDS | Acne |
| Hip Injuries | Epilepsy/Seizures | Cancer |
| Joint Replacements | Varicose Veins | Diabetes |
| Edema/Lymphedema | Carpal Tunnel | Warts |
| High/Low Blood Pressure | Whiplash | Pregnancy |
| TMJ Dysfunction | Vertigo | Fibromyalgia |

Are there any other health conditions we should know about? _____

_____

Is there anything else we need to know to make your treatment exceptional? _____

_____

| Initial Here |
| --- |
| _____ |

Your therapist may use some massage tools during your treatment as needed, which will be discussed before use to give you an opportunity to ask questions or decline. Initial here to indicate that you have given your consent for these tools.

## CLIENT CONSENT

(Please read thoroughly before signing.)
(Initial each statement to indicate your consent.)

_____ The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications, or manipulate bones. I further understand that massage therapy is not a substitute for medical attention. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health.

_____ I understand that cancelled or missed appointments, without 24 hours' notice, may result in being charged the full price of the appointment.

_____ I understand that massage therapy is used for the purpose of stress reduction, relief from muscular tension or spasm, and for increasing circulation and lymphatic flow. If I experience any pain or discomfort during the session, I will immediately inform my practitioner so the pressure or strokes can be adjusted to my level of comfort.

_____ I understand and agree that if I make any illicit or sexually suggestive remarks, or if I exhibit any sexual misconduct, I will be liable for full payment of the scheduled session, the appointment will end immediately, and I will not be allowed to return for future massages.

Signature _____ Date _____

FOR THERAPIST USE ONLY
MEDICAL NOTES RELATED TO INITIAL INTAKE

Therapist Name/Date _____
Notes _____
_____
_____
_____
_____
_____