IDLEWILD MASSAGE, LLC

Client History/Intake Form

Name: _____Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Occupation: _____

Email:_____ Referred by: _____

Do you where contact lenses? _____

Have you had massage before? _____

Please elaborate on your experience(s) with massage : _____
_____

What type of massage are you looking to receive today?

Relaxation ___ Deep Tissue/Therapeutic___ Pregnancy___ Senior___ Integrated Bodywork(functional)___ Other___

Do you exercise regularly? _____

Please list the medications you are currently taking and what they are for. (If you need more space for any answer, please use back of page) : _____
_____
_____

Are you involved in any other therapy at this time? If so, what, why, and how often? _____
_____
_____

<u>Primary Complaint</u>
Please briefly describe any troublesome areas and what results you would like to receive from your massage session:
_____
_____
_____

<u>Emergency Contact</u>

Name: _____ Ph. #: _____

Please list any previous injuries such as broken bones, severe sprains, strains, whiplash, traumas, etc. and approximate dates if known: _____

_____

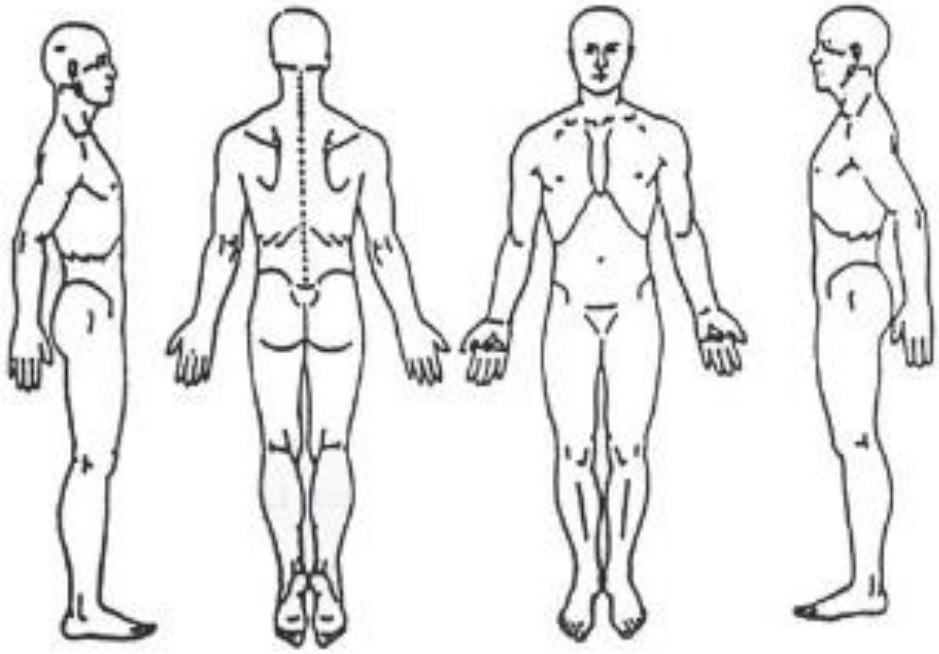
Please circle all symptoms or physical problems that you are currently experiencing or have in the past:

Allergies	Arthritis	Asthma	Artificial Joints	Back Conditions
Blood Clots	Bursitis	Contact Lenses	Diabetes	Disc Condition
Epilepsy	Fractures	Headaches	Heart Conditions	Insomnia
Joint Inflammation	Kidney Problems	Numbness/Tingling	Pregnant	Sciatica
Severe Bruises	Skin Conditions	Tendonitis	Varicose Veins	Other

Please explain any other conditions, symptoms, or problems you are having: _____

_____

On the pictures below please circle or draw arrows to the areas where you have discomfort, pain, or tension:



If you have a specific medical condition or specific symptoms, massage may be in conflict. A referral from your doctor may be required prior to services being provided. I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscle tension. If I experience any pain of discomfort during this session I will immediately inform the therapist and the pressure and/or strokes will be adjusted to my level of comfort. I further understand the massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medial specialist for any mental or physical ailment 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 sessions(s) given should be construed as such. Because massage should not be done under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapist's part should I forget to do so. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. I give my consent to receive care.

Client Signature: _____ Date: _____