

# Intuitive Touch Massage

## Client Intake Form and Health History

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

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Can I add you to my mailing list? Y N Birth Date: \_\_\_\_\_

Referred by: \_\_\_\_\_ Occupation: \_\_\_\_\_

Contact in case of Emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you had any serious illnesses, injuries or surgeries in the last two years? If so, please explain:

\_\_\_\_\_

What is your usual level of stress? Light Moderate High

What is your usual level of exercise? Daily Weekly Monthly Rarely

What is your usual exercise routine? \_\_\_\_\_

How much water do you drink a day? \_\_\_\_\_ glasses.

Which, if any, medications are you currently taking? \_\_\_\_\_

Do you wear: Contact Lenses Y N Do you wear Dentures Y N

Do you have a pacemaker? Y N Are you Right or Left Handed? R L

### Please circle any of the following conditions that apply to you:

- |                               |                                       |
|-------------------------------|---------------------------------------|
| Allergies                     | Low Back Pain                         |
| Arthritis                     | Migraines                             |
| Asthma or other Lung problems | Numbness, if so, where _____          |
| Back Problems _____           | Pregnant (how many months?) _____     |
| Bruise Easily                 | Seizures                              |
| Bursitis                      | Sciatica                              |
| Cancer _____                  | Scoliosis                             |
| Carpal Tunnel Syndrome        | Sensitivity to cold, heat or pressure |
| Chronic Fatigue               | Sleep Disorders                       |
| Diabetes                      | Sinuses                               |
| Fibromyalgia                  | Skin conditions _____                 |
| Frequent Headaches            | TMJ                                   |
| Heart Condition               | Varicose Veins                        |
| High or Low Blood Pressure    | Other _____                           |
| Irritable Bowel Syndrome      |                                       |

## Consent for Therapy

Please take a moment to carefully read the following and sign where indicated.

I understand that:

- ☉ The relationship between the client and the massage therapist is a confidential one and that all information provided to the therapist are kept confidential.
- ☉ This and future massages are solely for the purpose of therapeutic massage and that massage therapy should not be construed as a substitute for medical treatment and that I should see a physician or other healthcare specialist for any health care issues.
- ☉ I have the right to request that any procedure or technique be modified, changed, stopped or simply not performed.
- ☉ I understand that the only part of my body uncovered from a sheet is the part that is being worked on
- ☉ I will inform the massage therapist of any discomfort, so that the application of pressure may be adjusted to my level of comfort.
- ☉ The above information is accurate to the best of my knowledge and I agree to update the massage therapist is regard to changes in my health. I also agree that there will be no liability on the therapist's part if I should neglect to do so.
- ☉ It may be necessary to obtain permission from my healthcare provider to receive or continue therapy.
- ☉ Should I have to cancel an appointment for any reason, I agree to give the therapist a 24-hour notice.
- ☉ By signing this form I show that I have read this form and hereby freely give my permission to be massaged today **and** in future sessions.

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(Print Name)

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(Signature)

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(Date)