SERENITY MASSAGE AND BODYWORKS CLIENT INTAKE FORM

NAME: ____ DATE OF BIRTH: ______________

ADDRESS: ____

EMAIL: ____ PHONE: _______________

CONTACT PREFERENCE: Email: ____ Phone: _____ Text:_____

REASON FOR TREATMENT AND AREAS OF STRESS, PAIN OR TENSION ___________________________

____

HAVE YOU EVER HAD A PROFESSIONAL MASSAGE? YES___ NO___

IF YES, DO YOU HAVE ANY LIKES OR DISLIKES? ____

ARE YOU PREGNANT OR TRYING TO GET PREGNANT? YES___ NO___ IF YES, HOW FAR ALONG? ________

SKIN PROBLEMS OR ALLERGIES? YES___ NO___

ARTHRITIS OR JOINT DISORDERS? YES___ NO___

VARICOSE VEINS? YES___ NO___

HEART PROBLEMS? YES___ NO___

SPINAL PROBLEMS? YES___ NO___

HEADACHES? YES___ NO___

STRESS? YES___ NO___

DRUGS OR MEDICATIONS? YES___ NO___

MEDICAL CONDITIONS THAT YOUR THERAPIST SHOULD KNOW ABOUT? YES___ NO___

IF YES, PLEASE EXPLAIN____

PLEASE CHECK THE AREAS OF YOUR BODY THAT YOU GIVE PERMISSION TO RECEIVE MASSAGE:___ HEAD
___ FACE ___ NECK ___ SHOULDERS ___ BACK ___ CHEST ___ ARMS ___ HANDS

___ ABDOMEN ___ BUTTOCKS ___ LEGS `___ FEET

THERAPEUTIC BREAST MASSAGE WILL NOT BE PREFORMED. DRAPING (COVERAGE) WILL BE USED DURING THE SESSION AND ONLY THE AREAS BEING MASSAGED WILL BE UNDRAPED

I UNDERSTAND THAT THE MASSAGE I RECEIVE IS FOR THE BASIC PURPOSE OF RELAXATION AND RELIEF FROM MUSCULAR TENSION. IF AT ANY TIME I FEEL UNCOMFORTABLE FOR ANY REASON, I WILL ASK MY THERAPIST TO END THE SESSION. I UNDERSTAND THAT MASSAGE PRACTITIONERS DO NOT DIAGNOSE ILLNESS, DISEASE, OR ANY PHYSICAL OR MENTAL DISORDERS, NOR DO THEY PRESCRIBE MEDICAL TREATMENT, PHARMACEUTICALS, OR PERFORM SPINAL THRUST MANIPULATIONS. I HAVE STATED ALL MEDICAL CONDITIONS OF WHICH I AM AWARE OF TODAY AND WILL UPDATE MY MASSAGE THERAPIST OF ANY CHANGES IN MY HEALTH STATUS IN THE FUTURE.

SIGNATURE: ____ DATE: ___________________

SIGNATURE OF MASSAGE THERAPIST ____________________________________ DATE: __________