MINDY PACK STUDIOS

MASSAGE CLIENT INTAKE FORM

DATE : ____/____/____

CONTACT INFORMATION

Full Name _____

Date of Birth ____ /____ /____ Referred by _____

Pronouns _____

Home Address _____

City _____ Zip Code _____

Phone Number _____ Email _____

EMERGENCY CONTACT

Emergency contact name _____ Physician's name _____

Emergency contact relationship _____ Physician's phone # _____

Emergency phone # _____

MEDICAL INFORMATION

Date of initial visit _____

How would you rate your general health?

- ◯ Excellent
- ◯ Good
- ◯ Fair
- ◯ Poor

Have you had a professional massage before?

- ◯ Yes *(Date of last treatment)* _____
- ◯ No

List current medications & the conditions they are treating

_____

_____

_____

_____

_____

List any major accidents or surgeries (including dates)

_____

_____

_____

_____

_____

Please tell us about any allergies or hypersensitivities

_____

_____

_____

Reason for initial visit

_____

_____

_____

CLIENT NAME: _____ DATE : ____/____/____

HEAD / NECK

- ◯ Headaches / migraines
- ◯ Vertigo / dizziness
- ◯ Ringing in ears
- ◯ Hearing loss
- ◯ Vision problems
- ◯ Vision loss

RESPIRATORY

- ◯ Asthma
- ◯ Shortness of breath
- ◯ Chronic cough
- ◯ Bronchitis
- ◯ Emphysema
- ◯ Sinusitis
- ◯ Frequent colds
- ◯ Smoker
- ◯ Family history of respiratory difficulties

NERVOUS SYSTEM

- ◯ Sensory loss / change
- ◯ Numbness / tingling
- ◯ Sciatica
- ◯ Epilepsy
- ◯ Seizures
- ◯ Multiple sclerosis

MUSCULOSKELETAL SYSTEM

- ◯ Arthritis
- ◯ Family history of arthritis
- ◯ Osteoporosis
- ◯ Tendonitis
- ◯ Bursitis
- ◯ Jaw pain (TMJ)
- ◯ Pins / plates / wires / artificial joint

REPRODUCTIVE

- ◯ Pregnant
- ◯ Given birth
- ◯ Gynecological problems

CARDIOVASCULAR

- ◯ High blood pressure
- ◯ Low blood pressure
- ◯ Heart attack
- ◯ Stroke
- ◯ Heart disease
- ◯ Poor circulation
- ◯ Phlebitis / varicose veins
- ◯ Pacemaker
- ◯ Hemophilia
- ◯ Chronic congestive heart failure
- ◯ Family history of cardiovascular problems

SKIN & INFECTIONS

- ◯ Hepatitis
- ◯ HIV / AIDS
- ◯ Herpes
- ◯ Tuberculosis
- ◯ Lyme disease
- ◯ Infectious skin conditions

OTHER CONDITIONS

- ◯ Cancer
- ◯ Diabetes
- ◯ Unexplained weight loss
- ◯ Digestive conditions
- ◯ Fibromyalgia
- ◯ Chronic fatigue syndrome
- ◯ Depression
- ◯ Anxiety
- ◯ Organ Transplant
- ◯ Diabetic Pump
- ◯ Psychiatric disorder
- ◯ Pacemaker
- ◯ Other conditions _____

_____

_____

_____

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment. I give my permission to receive massage therapy. I understand that therapeutic massage is not a substitute for traditional medical treatment or medications. I understand that the massage therapist does not diagnose illnesses or injuries or prescribe medications. I have clearance from my physician to receive massage therapy. I understand the risks associated with massage therapy include, but are not limited to: Superficial bruising, Short-term muscle soreness, Exacerbation of undiscovered injury. I therefore release the company and and the individual massage therapist, Mindy Pack, from all liability concerning these injuries that may occur during the massage session. I understand the importance of informing my massage therapist of all medical conditions and medications I am taking, and to let the massage therapist know about any changes to these. I understand that there may be additional risks based on my physical condition. I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so he/she may adjust accordingly. I understand that I or the massage therapist may terminate the session at any time. I have been given a chance to ask questions about the massage therapy session and my questions have been answered.

By signing below, you agree to the following listed above:

Signature: _____ Date: _____

If under 18, Parent Signature: Contact Number: _____

Name: _____ Date: _____

Signature: _____