Medissage Integrative Therapies

Client Intake Form

Name____ Date______________

Address____

City_____________________________ State________________ Zip_____________________

Email____ Phone__________________

Preferred contact method: ___________________________ Text Messages accepted? Y___ N___

DOB______________ Occupation____

Emergency Contact Name __________________________________ Relationship ______________

Phone____________________________

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Are you currently taking any prescribed medications or dietary supplements? Y___ N___

Please explain: ____

____

Have you had a recent major surgical procedure or injury? Y___ N___

Please explain: ____

Are you currently seeing a Chiropractor, Physical Therapist, or Physician for ongoing issues? Y___ N___

Please explain: ____

____

Please circle your stress level:

Low 1 2 3 4 5 High

Please circle your pain level:

Low 1 2 3 4 5 High

Do you have any medication, food, and/or any lotion/oil allergies? Y___ N___

Please explain: ____

____

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Circle the following conditions that apply to you, past and present. Please add any comments to clarify the condition.

MUSCULOSKELETAL
Headaches
Joint stiffness/Swelling
Spasms/Cramps
Broken/Fractured bones
Strains/Sprains
Back, Hip pain
Shoulder, Neck, Arm, Hand pain
Leg, Foot pain
Chest, Ribs, Abdominal Pain
Jaw pain/TMJ
Problems walking
Tendonitis
Bursitis
Arthritis
Osteoporosis
Scoliosis
Other: _____

CIRCULATORY/RESPIRATORY
Dizziness
Shortness of Breath
Fainting
Cold feet or hands
Cold sweats
Stroke
Heart conditions
Allergies
Asthma
Blood pressure abnormalities
Tuberculosis
Other: _____

DIGESTIVE
Indigestion
Constipation
Intestinal gas/Bloating
Diarrhea
Irritable Bowel Syndrome
Crohn's Disease
Colitis
Allergies
Other: _____

NERVOUS SYSTEM
Numbness/Tingling
Fatigue
Sleep Disorders
Ulcers
Herpes/Shingles
Cerebral Palsy
Epilepsy
Chronic Fatigue Syndrome
Multiple Sclerosis
Muscular Dystrophy
Parkinson's disease
ALS
Other: _____

SKIN
Rashes
Allergies
Athletes Foot
Acne
Impetigo
Hemophilia
Other: _____

REPRODUCTIVE SYSTEM
Pregnancy
Endometriosis
Erectile Dysfunction
Other: _____

ADDITIONAL CONDITIONS
Loss of Appetite
Depression
Difficulty concentrating
Hearing Impairment
Visual Impairment
Diabetes
Fibromyalgia
Post/Polio Syndrome
Cancer
Other: _____

Comments:

_____

_____

_____

_____

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Consent for Therapy and Waiver of Liability

Client agrees as follows:

1. Client hereby freely consents to receipt of Massages services from the Therapist.
2. Client understands and agrees that they will provide the Therapist with complete and accurate health information and a written referral from Clients primary healthcare provider if Client is currently receiving care or has a specific medical condition or symptoms for which Client takes medications or receives periodic evaluations or treatments. Client understands that Massage Therapy is designed to be an ancillary health aid and is not suitable for primary medical treatment for any condition.
3. Client and Therapist have discussed the potential benefits and possible side effects of Massage Therapy and have agreed upon a course of focused attention and manual therapy for the predetermined goals of stress reduction, relief of muscular discomfort, and/or promotion of general health. Client has been given an opportunity to ask questions of the Therapist and has received all requested information.
4. Client understands that the unclothed body will be draped at all times for warmth, sense of security, and as a mark of Massage Therapy professionalism. Client agrees to immediately inform the Therapist of any unusual sensation or discomfort so that the application of pressure may be adjusted to the Clients level of comfort. Client understands that Massage Therapy is not sexual in any manner and that any illicit or suggestive remarks or behavior on the Clients part will result in an immediate termination of the Massage Therapy session. Client understands that payment will be expected in full; regardless if the massage is completed or not.
5. Client hereby assumes full responsibility for receipt of the Massage Therapy, and releases and discharges the Therapist from any and all claims, liabilities, damages, actions, or causes of action arising from the Therapy received hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the Therapist, to the fullest extent allowed by law.
6. Client, in signing this Consent for Therapy and Waiver of Liability ("Consent"), understands and agrees that this Consent will apply to and govern the current and all future Therapy sessions performed by the Therapist.

_____ _____

Client Signature Client Printed Name

_____

Date

_____ _____

Massage Therapist Signature Massage Therapist Printed Name

_____

Date