New Leaf Therapeutic Massage Client Intake

Personal Information

Today's Date ________________________________ Referred By ________________________________

Name _____________________________________ Date of Birth ________________________________

Address ____

Contact Number ____

Emergency Contact Name & Phone Number____

Email ____

Profession ____

1. Have you ever had a professional massage? Yes _____ No _____

   If yes, when was your last massage? ______________ How often do you receive massage? ________________

2. Do you perform any repetitive movements in your daily life? Yes_____ No_____

   If yes, please explain. ____

3. Do you exercise? Yes_____ No_____

   If so, how often and what type of exercise? ____

4a. On a scale from 1 to 10 (10 being the highest) how do you rate your overall level of stress in your daily life?

1----2----3-----4-----5----6----7----8-----9-----10

4b. How does your stress manifest itself? Check all that apply.

Muscle tension _____ Anxiety _____ Insomnia _____ Irritability _____ Other____________________

4c. Is there a particular area of your body where you are experiencing tension, stiffness, pain or other discomfort? Yes_____ No_____ If yes, please identify.____

5. Are there any areas which need to be avoided due to open skin, rashes or other contagions, sprains, breaks or other areas of discomfort or sensitivity such as hands, feet, face, etc.? Yes_____ No_____

   If yes, please identify ____

6. Do you have any difficulty lying on your stomach, side or back? Yes_____ No_____

   If yes, please explain ____

7. Are you allergic to any oils, nuts or herbs? Yes_____ No_____

   If yes, please list ____

8. Do you have any particular goals in mind for this massage session? Yes_____ No_____

   If yes, please identify ____

   ____

Medical Information

1. Are you currently being advised by a health care professional? Yes_____ No_____

   If yes, for what purpose? ____

   ____

2. Are you currently taking any medications? Yes_____ No_____

   If yes, for what purpose?____

   ____

3. Please describe any relevant surgeries you have had and approximate dates.

   ____

   ____

4. Please describe any accidents and/or injuries you have had and approximate dates.

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I, ______________________________, understand that massage is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch.

I understand the general benefits of massage, possible massage contraindications and the treatment procedures. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

I also understand that any illicit or sexually suggestive remarks or advances made by me at any point during my session will result in immediate termination of the session. I further understand that I will be held liable for payment "In full" for any session which has occurred partially or in full, or has been canceled without 24 hour notice.

Client Signature ______________________________ Date ____________________________

Parent Signature if under 18 ____

For treatment purposes only, please circle the conditions/symptoms which currently or previously have affected you. Your honesty is appreciated. All information given is confidential and received without judgement.

Circulatory and Respiratory

Allergies	Asthma	Blood clots	Cold feet or hands
Dizziness	Fainting	Heart condition	High blood pressure
Low blood pressure	Lymphedema	Shortness of breath	Sinus problems
Stroke	Swollen ankles	Varicose veins	

Other: ____

Musculo-Skeletal

Arthritis - Regular – Osteo – Rheumatoid		Bone or joint disease	Broken/fractured bones
Headaches/Migraines	Jaw pain/TMJ	Joint stiffness/swelling	Osteoporosis
Scoliosis	Spasms/cramps	Strains/sprains	Tendonitis/Bursitis

Other: ____

Nervous System

ADD/ADHD   Epilepsy   Chronic pain   Herpes/shingles   Multiple Sclerosis

Numbness/tingling   Paralysis   Spinal cord injury   Ulcers   Tourette's

Other: ____

Skin

Acne Allergies	Athlete's Foot	Cosmetic surgery	Eczema
Moles	Open Wounds	Psoriasis	Rashes
Rosacea	Warts		

Other: ____

Other

Cancer	Fibromyalgia	Hearing impaired	Visually impaired

Infectious disease (please list) ____

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Other congenital or acquired disabilities (please list) ____

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