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.

_____

_____

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".

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

Epilepsy	Chronic pain	Herpes/shingles	Multiple Sclerosis
Numbness/tingling	Paralysis	Spinal cord injury	Ulcers

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) _____

_____

Other congenital or acquired disabilities (please list) _____

_____