Serenity Now Massage Therapy Client Intake Form—PLEASE PRINT LEGIBLY

Name:_____ Phone:_____ DOB: ___/___/___

Address:_____

City:_____ST:_____ Zip: _____

Email: _____

Emergency Contact: _____ Relationship: _____ Phone:_____

Where did you hear about us? Google/Website Magazine Signs/Drive By Social Media

Current Client: _____ Other: _____

Occupation: _____

Please take a moment to carefully read and provide the following information. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated and a referral from your primary care provider may be required prior to service being provided.

Y N Do you frequently suffer from stress?
Y N Do you have diabetes?
Y N Do you have a thyroid condition?
Y N Do you experience frequent headaches?
Y N Are you pregnant? Due Date_____
Y N Do you suffer from arthritis?
Y N Are you wearing contact lenses or dentures?
Y N Do you bruise easily?
Y N Do you suffer from joint swelling?
Y N Have you ever had surgery? Year(s): _____
Y N Do you suffer from epilepsy or seizures?
Y N Do you have varicose veins?
Y N Do you have any contagious diseases?
Y N Do you have osteoporosis?
Y N Any broken bones in the past 2 years?
Y N Any injuries in the past two years?
Y N Do you suffer from back pain?
Y N Do you have disk herniation?
Y N Do you have numbness or stabbing pains?
Y N Do you use any topical hormones?
Y N Are you sensitive to touch or pressure in any areas?
Y N Do you have high blood pressure and/or take medications to manage blood pressure?
Y N Do you have cardiac or circulatory problems?
Y N Do you have any allergies or sensitivities? (i.e. nuts, iodine, shellfish, flowers, scents)
Y N Any other medical conditions or medications you are taking? _____

Additional Medical information/comments:_____

_____

_____

Over

Have you ever experienced a professional massage or bodywork session? Yes No

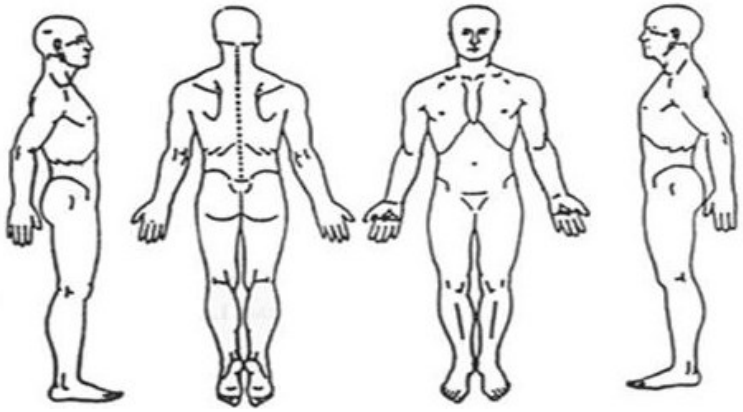
If so, how recently? _____

What are your goals for today's treatment?_____

_____

_____

Circle any specific areas you would like your therapist to focus on today:



What kind of pressure do you prefer? (Circle) Light (Swedish) Medium (Swedish) Firm (Deep Tissue)

Would you prefer any of the following areas be avoided? (Circle)

Abs Glutes Feet Face Scalp

I understand that the massage/bodywork treatment I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the treatment pressure may be adjusted to my level of comfort. I further understand that the massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioner's part should I fail to do so.

I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and that I will be liable for payment of the scheduled appointment in full. Therapists will maintain the National Certification Board for Massage & Bodywork Therapy Standards of Practice, viewable at http://www.ncbtmb.org/standards-practice.

Client Signature: _____

Date: _____

Parent Signature (if client under 18): _____