

Client Intake Form – Therapeutic Massage

Sea Shell Spa
1319 Magnavox Way
Fort Wayne IN 46804

Client Name: _____ Date: _____

Address: _____ Phone: _____

City/State/Zip: _____ Date of Birth: _____

Email: _____ Occupation: _____

Referred by: _____

Emergency contact: _____ Phone: _____

Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes No

Have you ever received professional massage/bodywork before? Yes No

How recently? _____

What types of massage/bodywork do you prefer? _____

What kind of pressure do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving massage/bodywork?

How do you feel today? _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)?

Yes No If yes, explain: _____

Are you currently under any medical supervision? Yes No

If yes, explain: _____

List the medications you currently take: _____

Are you wearing contacts? Yes No wearing dentures? Yes No hearing aid? Yes No

Are you pregnant? Yes No How many weeks along: _____

Have you had any injuries or surgeries in the past that may influence today's treatment?

Circle any of the following health conditions that you currently have (If you are unsure, please ask):

blood clots, infections, congestive heart failure, contagious diseases, pitted edema

Please answer honestly, as massage may not be indicated for the above conditions.

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current **Past** Muscle or joint pain

Current **Past** Neurological (e.g. MS, Parkinson's, chronic pain)

Current **Past** Muscle or joint stiffness

Current **Past** Cancer

Current **Past** Numbness or tingling

Current **Past** Epilepsy, seizures

Current **Past** Swelling

Current **Past** Headaches, Migraines

Current **Past** Bruise easily

Current **Past** Dizziness, ringing in the ears

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Current **Past** Sensitive to touch/pressure
Current **Past** High/Low blood pressure
Current **Past** Stroke, heart attack
Current **Past** Varicose veins
Current **Past** Shortness of breath, asthma
Current **Past** Scoliosis
Current **Past** Allergies _____
Current **Past** Endocrine/thyroid conditions
Current **Past** Memory Loss, confusion, easily
overwhelmed

Current **Past** Digestive conditions (e.g. Crohn's, IBS)
Current **Past** Gas, bloating, constipation
Current **Past** Kidney disease, infection
Current **Past** Arthritis (rheumatoid, osteoarthritis)
Current **Past** Osteoporosis, degenerative spine/disk
Current **Past** Broken bones
Current **Past** Diabetes
Current **Past** Depression, anxiety

Comments: _____

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/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 or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given 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 I will be liable for payment of the scheduled appointment.

COVID-19 Consent for Treatment

I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be elevated risk of disease transmission, including COVID-19. By Signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time. I voluntarily agree to give my consent to receive care and assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto.

Date: _____
Client Signature/ Parent or Guardian Signature (in case of a minor, *Parent or Guardian must remain present*)

Date: _____
Massage Therapist Signature