Client Intake Form – Massage/Athletic Therapy

Personal Information:

Name ______________ Phone (Day) ______________ Phone (Eve) ______________

Address ______________

City/State/Zip ______________

email ______________ Date of Birth ______________ Occupation ______________

Emergency Contact ______________ Phone ______________

The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge.

Date of Initial Visit ______________

1. Have you had a professional massage before? Yes No

   If yes, how often do you receive massage therapy? ______________

2. Do you have any difficulty lying on your front, back, or side? Yes No

   If yes, please explain ______________

3. Do you have any allergies to oils, lotions, or ointments? Yes No

   If yes, please explain ______________

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( ) ?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No

   If yes, please describe ______________

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No

   If yes, please describe ______________

8. Do you experience stress in your work, family, or other aspect of your life? Yes No

   If yes, how do you think it has affected your health?

   muscle tension ( ) anxiety ( ) insomnia( ) irritability ( ) other ______________

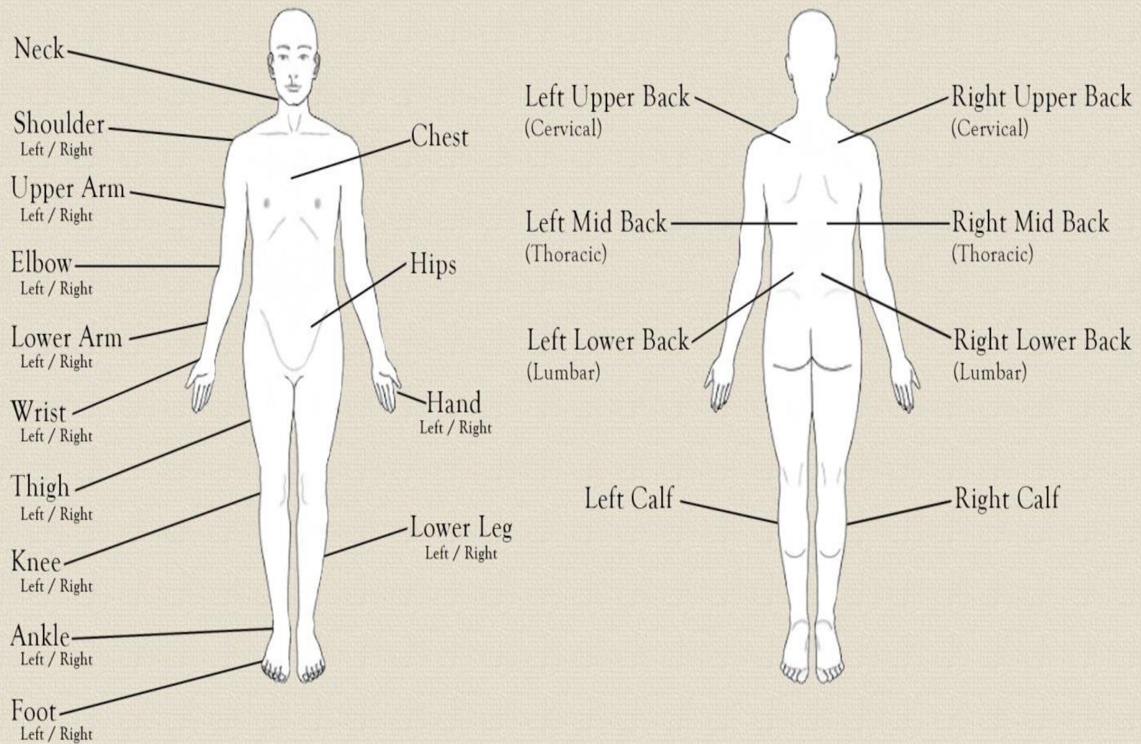
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

   If yes, please identify ______________

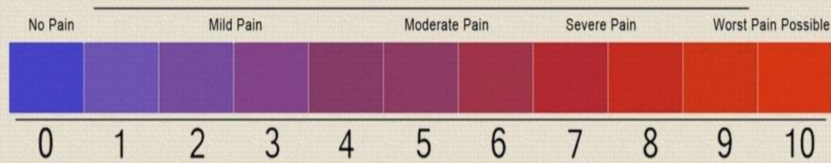
10. Do you have any particular goals in mind for this massage session? Yes No

    If yes, please explain ______________

11. Please fill in pain chart below?



Circle the area or areas that best describe the location of the pain you are feeling



On a scale of 1 to 10, with 1 being the least and 10 being the most painful, Circle how you would rate that pain

Check any of the following terms that describe your pain

- ☐ Aching ☐ Burning ☐ Sore ☐ Pounding ☐ Crampy ☐ Tight
- ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Pinching ☐ Dull ☐ Tingling
- ☐ Prickling ☐ Deep ☐ Tender ☐ Beating ☐ Itchy ☐ Tiring
- ☐ Splitting ☐ Intense ☐ Unbearable ☐ Cold

Medical History

In order to plan a massage session that is safe and effective,

I need some general information about your medical history.

11. Are you currently under medical supervision? Yes No
    If yes, please explain ____________________
12. Do you see a chiropractor? Yes No If yes, how often? ____________________
13. Are you currently taking any medication? Yes No
    If yes, please list ____________________
14. Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) Fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) pregnancy If yes, how many months?

Please explain any condition that you have marked above ____________________

____

____

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? ____________________

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Draping will be used during the session – only the area being worked on will be uncovered.

Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session.
Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

16. I, ____________________ understand that the massage I receive is provided for the purpose of relaxation and/or therapeutic means. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 that I am aware of. I understand that massage therapists 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. Focused attention and manual therapy will be given as agreed upon by therapist and client for the predetermined goals of stress reduction, relief of muscular discomfort, and/or health promotion. The therapist has discussed the potential benefits and possible side effects of this therapy and I have been given an opportunity to ask questions. Because massage 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Written referral is requested from your primary care provider if:

1. You are currently receiving care, or
2. You have a specific medical condition or symptoms for which you take medication or receive periodic evaluation or treatment.

I understand that by signing this form, I give my consent to receive the treatment discussed in this and all future sessions and agree that my presence at subsequent sessions shall be construed to be validation of this written consent. I have read this form and hereby freely give my permission to be massaged.

Disclaimer: By signing below, I attest that all information provided is true and accurate to the best of my knowledge. I also understand that:

- Massage/Athletic Therapists 'are not a doctor and cannot prescribe medications or diagnose medical conditions.
- A Therapist does not discriminate on the basis of race, religion, sexual preference or gender.
- Therapist reserves the right to end session in the case of sexual innuendo or advances from client, and client has same right in instance of sexual advances or innuendo from therapist.
- Both the therapist and client both have the right to terminate the session if there is any kind of belligerent behavior.

PLEASE NOTE:

THERE WILL BE A $30 CANCELLATION FEE FOR ANY APPOINTMENT CANCELLED WITHIN 24 HOURS OF THE SCHEDULED APPOINTMENT.

THANK YOU

PROFESSIONAL MOBILE THERAPY

Client Signature:____ Date:___________________

Massage Therapist Signature:_______________________________ Date:___________________

If you would like a Fire Cupping Treatment Please Read and Sign the Consent form Below.

Thank You

Fire Cupping Therapy Informed Consent Form

About Cupping Therapy

- This remarkable therapy utilizes negative pressure, rather than tissue compression, for superior results in a wide array of bodywork techniques. Suction cup therapy is a traditional, time-honored treatment that remains favored by millions of people worldwide because it's safe, comfortable and remarkable results.

Why Cupping is so effective in bodywork?

- By creating suction and negative pressure, cupping therapy lifts connective tissue, releases, rigid tissue and loosens adhesions. Cupping pulls stagnation, waste, and toxins to the skin level where it can be easily flushed out by the lymphatic and circulatory system.

- Cupping techniques bring blood flow and nutrition to stagnant areas. The pulling action engages the parasympathetic nervous system, thus allowing deep relaxation throughout the entire body.

- Cupping therapy is far more effective and long lasting than any other therapeutic bodywork applied alone.

What are the marks that can occur from cupping?

- They are not bruises. They are metabolic waste, toxins, and other stagnant material that have been freed from the underlying tissue and brought to the surface where they can more easily be flushed away. These marks can last anywhere from a few hours to a few weeks and are not tender to the touch.

- As treatments continue, the marks will occur less and less as a result of stagnation and toxicity being expelled from the body.

I, ___________________________, (print client's full name) confirm that the Massage therapy practitioner, Brummund, Chad has explained the possibility of cupping marks that can occur from the cupping site. I understand the benefits, side effects and contraindications of cupping therapy and will not hold the practitioner responsible.

Client Signature:____ Date:___________________

Massage Therapist Signature:_______________________________ Date:___________________