WARM TOUCH
Massage

Client Intake Form

Personal Information

Name: _____ Email: _____
Address: _____
Best Phone: _____ Preferred Method of Contact: Mail/ Phone/ Text/ Email/ Do not
Occupation: _____ Birthdate: _____ Referred by: _____
Emergency Contact: _____ Phone: _____

Massage Information

Have you ever had a professional massage before? Yes No If yes, when? _____
Reason(s) for your visit: _____
Areas(s) to focus on? _____
What kind of pressure do you like on a scale of 1 – 10, with 1 being the lightest and 10 the heaviest? _____

Medical History

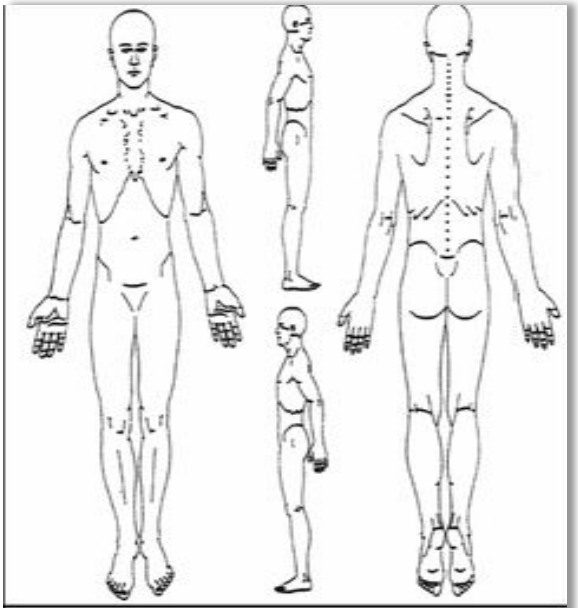
Are you currently under medical supervision? Yes No If yes, how so? _____
_____
Do you see a chiropractor? Yes No If yes, how often? _____
Are you using any medication(s)? If so, for what? _____
_____

Please mark any condition or issue with which you have:

___Accident
___Arthritis, tendonitis
___Blood pressure
___Diabetes
___Headache/Migraine
___Joint replacement/ surgery
___Numbness
___Recent injuries
___Sprains, strains
___Varicose veins
___Allergies
___Blood clots
___Cancer, tumors
___Fibromyalgia
___Heart/circulation
___Neck/back injuries
___Pregnancy
___Skin condition
___TMJ problems

Explain any conditions that you have marked above:

_____
_____
_____
_____
_____
_____
_____
_____



Please mark in the diagram above any areas where you have pain or discomfort.

I, _____(print name) understand that the massage 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 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. 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.

Signature of client _____ Date _____

Signature of massage therapist _____ Date _____