

Back and Body Massage

Client Intake Form

Name: _____ Phone: _____ Email: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

How did you hear about Back and Body Massage? _____

Emergency Contact Person: _____ Relationship: _____ Phone: _____

Important: *If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to services being provided.*

Have you ever experienced a professional massage? Yes No How recently? _____

Do you have any, or have you had any of the following conditions? Mark all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Vision problems, contacts | <input type="checkbox"/> Constipation, diarrhea |
| <input type="checkbox"/> Jaw pain, TMJ problems | <input type="checkbox"/> Asthma or lung condition | <input type="checkbox"/> Numbness or tingling |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Muscle, bone injuries | <input type="checkbox"/> Cancer, tumors |
| <input type="checkbox"/> Sprains, strains | <input type="checkbox"/> Arthritis, tendonitis | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Spinal column disorders | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies, sensitivities |
| <input type="checkbox"/> Heart, circulatory problems | <input type="checkbox"/> Tension, stress | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Rashes, athlete's foot | <input type="checkbox"/> Infectious diseases | <input type="checkbox"/> Taking medication? |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> High/low blood pressure | |
| <input type="checkbox"/> Acute injuries in the past two years | <input type="checkbox"/> Hernia | |

Other Medical Conditions not listed above? _____

How would you describe your general health condition? Please elaborate.

- Excellent _____
- Good _____
- Average _____
- Below Average _____
- Poor _____
- Terminal _____

Minor Consent: By my signature below, I hereby authorize Michael Montijo, LMT, DBA Back and Body Massage to administer massage to my child or dependent as he deems necessary. I understand I am advised to be present during the massage.

I choose to be present during the massage as advised: Yes No Please Initial: _____

PARENT OR GUARDIAN: _____ DATE: _____

Please read the following information carefully and sign below:

I understand that the massage therapy I receive from the massage therapist is for purposes of stress reduction, the reduction of muscle tension/spasm, the improvement of circulation, and to enhance my overall wellness. If my reason for seeking massage therapy changes, I understand that it is my responsibility to inform the massage therapist. If at any time during my session I feel uncomfortable, I may request that the therapist stops the session immediately. I understand that a massage therapist neither diagnoses nor treats illness or disease, nor performs any spinal/skeletal manipulations. I understand that the massage therapist does not prescribe medications. I understand that massage therapy is not a substitute for medical examinations or diagnosis. I take it upon myself to seek proper medical attention from a physician for any physical ailment that I may have. I understand that I will be covered during the session, and only the areas that are treated will be uncovered during treatment.

Client Signature

Date

LMT Signature

Date

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Areas Not Treated	Areas which may be treated with client approval	Areas treated in a Normal Session
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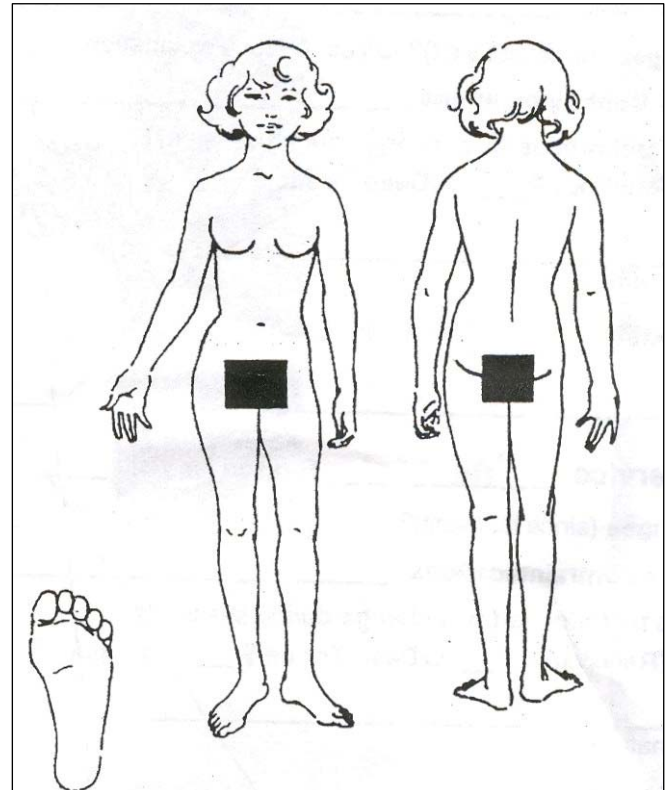
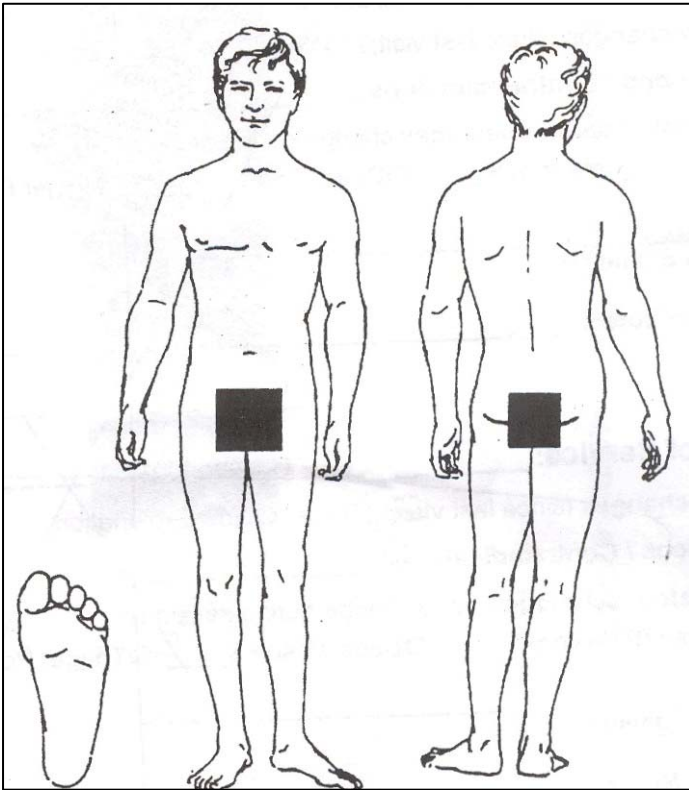
Place an "X" over the areas you DO NOT want treated. Indicate any discomfort or sensation you may be experiencing by choosing the appropriate marks and placing the mark(s) over the affected area.

P = Pain

O = Numbness

¥ = Tingling

/// = Tension



Massage Therapist Use Only

SOAP Notes: _____

