

THE BUCKHEAD MASSAGE COMPANY

CONFIDENTIAL INTAKE FORM – MASSAGE

Welcome! We want to make your appointment as comfortable and pleasant as possible. Should you have questions regarding your therapy session, please let us know.

(Please Print)

CLIENT INFORMATION					
Client's last name:		First:	Middle:		
Occupation:	Email:	Phone no.:	Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			City:	State:	ZIP Code:
Referred by:					

MESSAGE INFORMATION			
Have you ever received professional massage/bodywork before?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
What types of massage/bodywork do you prefer?	<input type="checkbox"/> Swedish	<input type="checkbox"/> Deep Tissue	<input type="checkbox"/> Other
What kind of pressure do you prefer?	<input type="checkbox"/> Light	<input type="checkbox"/> Medium	<input type="checkbox"/> Firm
What are your goals/expectation for this therapy session?	_____		

HEALTH INFORMATION				
Are you taking medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, describe: _____	
Are you wearing contacts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Are you wearing dentures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Are you wearing a hairpiece?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Are you pregnant? (for women)	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Have you had any injuries or surgeries in the past that may influence today's treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, describe: _____	
Do you have any of the following today?	<input type="checkbox"/> Sunburn/Burn	<input type="checkbox"/> Inflammation	<input type="checkbox"/> Cuts/Bruises	<input type="checkbox"/> Skin rash
	<input type="checkbox"/> Severe pain	<input type="checkbox"/> Poison ivy	<input type="checkbox"/> Cold/Flu	<input type="checkbox"/> Headache

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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	Dizziness, ringing in the ears
Current	Past	Muscle or joint stiffness	Current	Past	Digestive conditions
Current	Past	Numbness or tingling	Current	Past	Gas, bloating, constipation
Current	Past	Swelling	Current	Past	Kidney disease
Current	Past	Bruise easily	Current	Past	Arthritis (rheumatoid, osteoarthritis)
Current	Past	Sensitive to touch/pressure	Current	Past	Osteoporosis, deg. spine/disk
Current	Past	High/low blood pressure	Current	Past	Scoliosis
Current	Past	Stroke, heart attack	Current	Past	Allergies _____
Current	Past	Varicose veins	Current	Past	Diabetes
Current	Past	Cancer	Current	Past	Endocrine/thyroid conditions
Current	Past	Neurological (e.g. MS, Parkinson's)	Current	Past	Depression, anxiety
Current	Past	Epilepsy, seizures	Current	Past	Fibromyalgia
Current	Past	Headaches, Migraines	Current	Past	Hepatitis, HIV
Current	Past	Shortness of breath, asthma	Current	Past	Sciatica

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. Furthermore, I also understand that I will be liable for payment for any late cancellations of future appointments. Understanding all of this, I give my consent to receive care. With my signature I acknowledge the cancellation policy that *I may reschedule or cancel your appointment without charge at least 12 hours prior to your scheduled appointment. Cancellations of less than 12 hours will be charged 50% of the scheduled service price.*

Client Signature _____

Date ____/____/____

Parent or Guardian Signature _____
(in case of a minor)

Date ____/____/____