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: ❑ M ❑ F
Street address:			City:	State:	ZIP Code:
Referred by:					

MASSAGE INFORMATION			
Have you ever received professional massage/bodywork before?	❑ Yes	❑ No	
What types of massage/bodywork do you prefer?	❑ Swedish	❑ Deep Tissue	❑ Other
What kind of pressure do you prefer?	❑ Light	❑ Medium	❑ Firm
What are your goals/expectation for this therapy session?	____		

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

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 Muscle or joint stiffness
Current Past Numbness or tingling
Current Past Swelling
Current Past Bruise easily
Current Past Sensitive to touch/pressure
Current Past High/low blood pressure
Current Past Stroke, heart attack
Current Past Varicose veins
Current Past Cancer
Current Past Neurological (e.g., MS, Parkinson's)
Current Past Epilepsy, seizures
Current Past Headaches, Migraines
Current Past Shortness of breath, asthma

Current Past Dizziness, ringing in the ears
Current Past Digestive conditions
Current Past Gas, bloating, constipation
Current Past Kidney disease
Current Past Arthritis (rheumatoid, osteoarthritis)
Current Past Osteoporosis, deg. spine/disk
Current Past Scoliosis
Current Past Allergies ___________________
Current Past Diabetes
Current Past Endocrine/thyroid conditions
Current Past Depression, anxiety
Current Past Fibromyalgia
Current Past Hepatitis, HIV
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 my appointment without charge at least 12 hours prior to my scheduled appointment. Cancellations of less than 12 hours will be charged 50% of the scheduled service price.*

Client Signature________________________________ Date _____/______/_____________

Parent or Guardian Signature _____________________ Date _____/______/_____________
(in case of a minor)