Kneaded Relief; LLC Client Intake Form

Name _____ Phone _____
Address _____
_____
Email _____ Date of Birth _____
Occupation _____
Referred by: _____
Emergency Contact Phone _____
How did you hear about me? _____
_____

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

1) Have you had a professional massage before? Yes No Do you regularly? Yes No
If yes, how often? _____
If no, how often would you like to? _____
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, ointments, or skin care products? Yes No
If yes, please explain _____
4) Do you have allergies to medications, foods, or environmental allergens? Yes No
If yes, please explain _____
5) Do you sit for long hours at a workstation, computer, or driving? Yes No
If yes, please describe _____
6) Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please describe _____
7) Do you experience stress in your work, family, or other aspect of your life? Yes No
8) What area of your body do you experience tension, stiffness, pain or other discomfort regularly?
If yes, please explain _____

Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history. Please check any condition listed below that applies to you:

( ) Abdominal/Digestive Problems
( ) Allergies/Sensitivity
( ) Anxiety
( ) Arthritis
( ) Artificial Joint (where)
( ) Asthma or Lung Cond.
( ) Auto-Immune Disease (AIDS, HIV)
( ) Back/Neck Problems
( ) Broken/Dislocated Bones (when/where)
( ) Bruise Easily
( ) Bursitis (where)
( ) Cancer (kind)
( ) Carpal Tunnel
( ) Chronic Pain (where)
( ) Circulatory Disorder
( ) Contagious Skin Condition
( ) Current Fever
( ) Decreased Sensation/tingling/numbness
( ) Deep Vein Thrombosis/Blood Clots
( ) Depression/Panic Disorder/Other Psych
( ) Diabetes
( ) Emphysema
( ) Epilepsy
( ) Fatigue
( ) Headaches/Migraines
( ) Hearing Problems
( ) Heart Condition
( ) Hepatitis (A, B or C)
( ) Hernia
( ) High or Low Blood Pressure
( ) Insomnia
( ) Joint Disorder/RA/OA/Tendonitis
( ) Lymphedema
( ) Open Sores or Wounds
( ) Osteoporosis
( ) Phlebitis
( ) Pregnancy (how many weeks)
( ) Recent accident or injury

( ) Recent Fracture (where)
( ) Recent Surgery (last 5 years)
( ) Scoliosis
( ) Sinus Problems
( ) Sprains/Strains
( ) Strokes
( ) Swollen Glands
( ) Tennis Elbow
( ) Tension/Stress
( ) TMJ Disorder/Jaw Pain
( ) Varicose Veins
( ) Other

9) Do you see a chiropractor? Yes No
If yes, how often?_____
10) Are you currently taking any medication? Yes No
If yes, please list name and reason_____
11) Please list any injuries or surgeries in last 5 years: _____
_____
_____

Is there anything else about your medical history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you? ___

_____
_____

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to: need to move or change position, sighing, yawning, change in breathing, stomach gurgling, emotional feelings and/or expression movement of intestinal gas, energy shifts, falling asleep, reliving memories.

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.

I, _____ 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. This is a therapeutic massage and any Sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated and will cause the session to be terminated and I will be liable for payment of the scheduled treatment. I understand that if the massage therapist starts a session late, she will make it up to me at the end of my session if possible, or will reduce my fee accordingly. I understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized. 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. I understand that I am receiving massage therapy at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.

Signature of client _____Date_____

Signature of Massage Therapist _____Date_____