

Massage Intake Form

Name: _____ Home Phone: (____) _____ Cell Phone: (____) _____

Address: _____ City: _____ State/Zip: _____

DOB: ___/___/___ Emergency Contact Name: _____ Contact Phone: (____) _____

Email (To receive appointment reminders and special offers): _____
 Your e-mail address and contact information will not be sold or given to anyone else

How did you hear about us? Please be specific: _____

Have you ever received a professional massage? _____ Which type? _____

Please let us know areas you would like your therapist to focus on: _____

Are there any areas of your body that you DO NOT want massaged? _____

If you have certain medical conditions or symptoms, receiving a massage may aggravate or worsen that condition. A referral from your primary care provider may be requested prior to receiving massage if you have any of these conditions.

Please mark All Current and Past Conditions:

<input type="checkbox"/> Skin Allergies specify _____ <input type="checkbox"/> Rashes, Eczema <input type="checkbox"/> Athletes Foot <input type="checkbox"/> Herpes/Cold Sores <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Burns Including Sunburn <input type="checkbox"/> Asthma <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Allergies Specify _____ <input type="checkbox"/> Shingles <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Pinched Nerve <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Chronic Pain _____	<input type="checkbox"/> Bone/Joint Disease <input type="checkbox"/> Tendonitis/Bursitis <input type="checkbox"/> Arthritis/Gout <input type="checkbox"/> Jaw Pain (TMJ) <input type="checkbox"/> Cramping/Spasm/Soreness <input type="checkbox"/> Heart Condition <input type="checkbox"/> Phlebitis/Varicose Veins <input type="checkbox"/> Blood Clots <input type="checkbox"/> High/Low Blood Pressure <input type="checkbox"/> Lymphedema <input type="checkbox"/> Thrombosis/Embolism <input type="checkbox"/> Cancer/Tumors <input type="checkbox"/> Bladder/Kidney Ailments <input type="checkbox"/> Diabetes	<input type="checkbox"/> Drug/Alcohol Abuse <input type="checkbox"/> Migraine/Headaches <input type="checkbox"/> Anxiety/Stress Syndrome <input type="checkbox"/> Depression <input type="checkbox"/> Pregnancy: Trimester _____ Additional Client Remarks: _____ _____ _____ _____
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Are you on any medications (List them)? _____

If you are currently experiencing a cold, flu or fever, your session MUST be rescheduled for 48 hrs after symptoms subside.
 Comments: _____

Disclaimer: This place of business will not be held liable for any injury or condition that arises from application of massage despite completion of this form. The form is intended as an assessment tool only and serves as a guide for the application of massage.

Cancellation Policy: By signing this intake form you agree that if you need to cancel or reschedule an appointment, you will provide us with a minimum of twenty four hours notice to avoid being charged a fee. Any cancellations within twenty four hours of your scheduled time will be subject to the current cancellation fee.

I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I agree to inform my massage therapist immediately of any change in the conditions stated above. I acknowledge that this information is confidential and intended for review by massage therapists; that a medical referral may be requested of me; and that LaVida Massage is not liable for the management of any condition. I also understand that any illicit or sexually suggestive remarks or advances made by myself will result in immediate termination of the session, and I will be liable for full payment of the appointment.

Client Signature: _____ Date: _____

If a Minor, Signature of Guardian/Parent is required: _____ Date: _____

