Client Intake Form – Therapeutic Massage

Name _____ Phone _____

Address_____City/State_____

Email _____ Date of Birth _____ Occupation _____

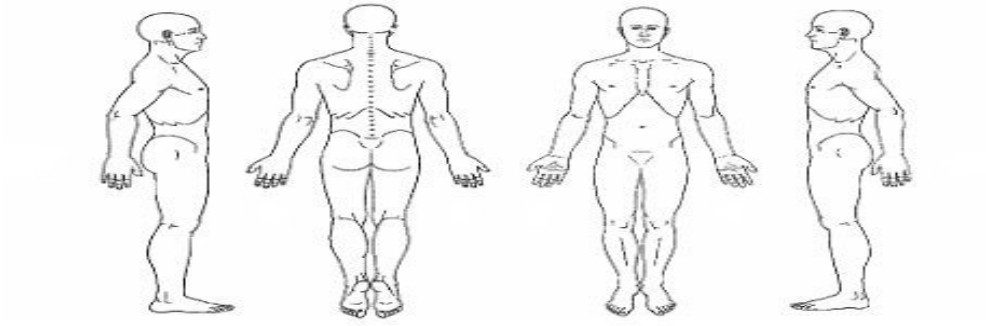
Emergency Contact _____ Phone _____

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

Date of Initial Visit _____

1. Have you had a professional massage before? Yes No
   If yes, how often do you receive massage therapy? _____
2. Do you have any allergies to oils, lotions, or ointments? Yes No
   If yes, please explain _____
3. Do you have any difficulty lying on your front, back, or side? Yes No
   If yes, please explain _____
4. Do you have sensitive skin? Yes No
5. Please circle if you are wearing any of the following: Contacts Dentures Hearing Aid
6. Do you sit for long hours at a workstation, computer, or driving? Yes No
   If yes, please explain _____
7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
   If yes, please explain _____
8. Do you experience stress in your work, family, or other aspect of your life? Yes No
   If yes, how do you think it has affected your health? Please Circle
   Muscle Tension Anxiety Insomnia Irritability
   Other_____
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain, or other discomfort? Yes No
   If yes, please explain _____
10. Do you have any goals in mind for this massage session? Yes No
    If yes, please explain _____

Circle any specific areas you would like the massage therapist to concentrate on during the session.



Medical History

In order to plan a massage session that is safe and effective, we need general information about your medical history.

1. Are you currently under medical supervision? Yes No
   If yes, please explain _____
2. Do you see a chiropractor? Yes No
   If yes, how often? _____
3. Are you currently taking any medication? Yes No
   If yes, please list _____
4. Please check any conditions listed below that apply to you:

( ) contagious skin condition	( ) phlebitis
( ) open sores or wounds	( ) deep vein thrombosis/blood clots
( ) easy bruising	( ) joint disorder/rheumatoid arthritis
( ) recent accident/injury	( ) osteoporosis
( ) recent fracture	( ) epilepsy
( ) recent surgery	( ) headaches/migraines
( ) artificial joint	( ) cancer
( ) sprains/strains	( ) diabetes
( ) current fever	( ) decreased sensation
( ) swollen glands	( ) back/neck problems
( ) allergies/sensitivity	( ) fibromyalgia
( ) heart condition	( ) TMJ
( ) high/low blood pressure	( ) carpal tunnel syndrome
( ) circulatory disorder	( ) tennis elbow
( ) varicose veins	( ) pregnancy – If yes, how many months? _____
( ) atherosclerosis	( ) osteoarthritis/tendonitis

Please explain any conditions that you have checked above _____
_____

15. Is there anything else about your health history that you think would be useful for your massage therapist to know in order to plan a safe and effective massage session for you?_____
_____

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/legal guardian during the entire session.
Informed written consent must be provided by a parent/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. Furthermore, I 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 should be construed as such. Because massages should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions, and answered all questions honestly. 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.

Signature of Client _____ Date _____
Signature of Massage Therapist _____ Date _____

HARPETH CHIROPRACTIC CENTER

DR. JAMES W. MOORE

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Licensed Massage Therapy Policy Change

The following policy changes will be in effect after January, 1st 2017. Please initial on each line and sign.

_____ We may request a credit card to keep on file to reserve your appointment.

_____ No shows and appointment changes with less than a 24-hour notice will be charged a $30 fee.

_____ If we do not have a credit card on file, you will be asked to pay the $30 fee prior to rescheduling your appointment.

_____ No children under 10 years old are to be left unattended during a massage. Please make arrangements prior to your appointment.

_____ You must have a current phone number and/or email on file. Please update with the front desk if there are any changes.

I have read and understand Harpeth Chiropractic Centers Massage Therapy Policy Changes.

_____ _____

Print Name Patient Signature

_____

Date