

Massage Therapy Intake & Consent Form

Name: _____ Birth Date: ____ / ____ / _____ Age: _____

Address: _____ City: _____ State: ____ ZIP: _____

Phone #: (home) _____ (work) _____ (cell) _____

E-mail address: _____

How did you hear about me: _____

Emergency Contact: _____ Relation: _____ Phone #: _____

Regular Medical Doctor: _____

Lifestyle & Occupation

Please circle the answer closest to how you presently feel (1 = poor, 5 = excellent):

Quality of sleep 1 2 3 4 5
Energy level 1 2 3 4 5
Exercise habits 1 2 3 4 5
Fluid intake 1 2 3 4 5

Occupation: _____

How many hours per week on average? _____

How do you spend most of your work day?

Sitting Sitting w/ mostly computer work Standing

Light manual labor Manual labor Hard Manual Labor

Current Stress Level: Constant Moderate Mild None

Health History

Please note any health conditions you have experienced. Be sure to indicate if it is a current or a past condition.

List any health conditions, major accidents, major illnesses or surgeries (include approximate DATES):

List all medications, vitamins, minerals, or supplements you are taking: _____

List all known allergies (including medications, foods, seasonal, oils/lotions, scents etc.): _____

Is there anything else about you or your health that I should know?

Have you ever received massage therapy before? No Yes (Date of last massage: _____)

Policies If you need to reschedule your appointment, please give me AT LEAST 4 HOURS NOTICE so that I can fill the space. If you do not show up for an appointment I will bill you 50% of the service(s) reserved. Please understand that this policy is in place because I do my best to respect you and your time and I expect the same from you in return. I reserve the right to substitute with an equally qualified massage therapist in the event I am sick or otherwise unable to serve you.

Consent for Care I hereby state that the above information that I have filled in is true and accurate to the best of my knowledge. I authorize my massage therapist to communicate with my Medical Doctor as deemed necessary for my treatment. I understand that my personal and medical information (both written and spoken) is confidential and will only be disclosed to third parties with my permission. I also understand that I am expected to notify my massage therapist if there are any changes to my health OR if I am uncomfortable with ANY part of my massage therapy treatments. I am aware that I need to consult with my Medical Doctor PRIOR to receiving massage therapy if I am experiencing any contraindicated conditions in which it would be inadvisable for me to receive massage. I understand that I will be receiving massage therapy as an adjunctive form of healthcare only, and that I must continue to receive appropriate medical care from my Medical Doctor.

Signature _____ Date _____