Massage Fort Myers, Inc.

CLIENT INTAKE FORM (CONFIDENTIAL)

Name _____ Phone (_____)_____ DOB _____

Street _____ City_____ State _____ Zip _____

E-Mail _____ How did you hear about us? _____

Please check **all** boxes below

❑ Yes ❑ No	Do you frequently suffer from stress?	❑ Yes ❑ No	Do you have diabetes?
❑ Yes ❑ No	Do you experience frequent headaches?	❑ Yes ❑ No	Are you pregnant?
❑ Yes ❑ No	Do you suffer from arthritis?	❑ Yes ❑ No	Are you wearing contact lenses?
❑ Yes ❑ No	Are you wearing dentures?	❑ Yes ❑ No	**Are you taking a blood thinner?**
❑ Yes ❑ No	Are you taking blood pressure medication?	❑ Yes ❑ No	Do you suffer from epilepsy or seizures?
❑ Yes ❑ No	Do you suffer from joint swelling?	❑ Yes ❑ No	Do you have varicose veins?
❑ Yes ❑ No	Do you have any contagious diseases?	❑ Yes ❑ No	Do you have osteoporosis?
❑ Yes ❑ No	Do you have any allergies?	❑ Yes ❑ No	Do you bruise easily?
❑ Yes ❑ No	Any broken bones in the past two years?	❑ Yes ❑ No	Any injuries in the past two years?
❑ Yes ❑ No	Do you have cardiac or circulatory problems?	❑ Yes ❑ No	Do you suffer from back pain?
❑ Yes ❑ No	Do you have numbness or stabbing pains?	❑ Yes ❑ No	Have you ever had surgery?

Explain any of the above: _____

_____

❑ Yes ❑ No Are you taking any medications I should know about? Please list _____

_____

❑ Yes ❑ No Do you have tension or soreness in a specific area? Please specify _____

_____

❑ Yes ❑ No Are you sensitive to touch or pressure in any area? Please specify _____

_____

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 practitioner so that the pressure 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, or other qualified medical specialist, for any mental or physical ailment of which I am aware. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness. 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. 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.

_____ _____

Client Signature **Date**

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

_____ _____

Parent/Guardian Signature Date