Client Intake Form - Therapeutic Massage of Pepperell

Name_____Phone(home)_____(cell)_____

Mailing address_____

email _____Date of Birth _____Age ____Occupation_____

emergency contact _____Phone _____

Who may we thank for your referral? _____

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

Date of initial visit _____

Have you had professional trigger point therapy before? Yes No

If yes, for what condition?_____

Have you had professional massage therapy before? Yes No

If yes, how often?_____

Do you have any difficulty lying on your front, back, or side? Yes No

if yes, please explain _____

Do you have sensitive skin or allergies to oils, lotions, or ointments? Yes No

If yes, please explain _____

Are you wearing contact lenses ( ) or a hearing aid ( )?

Do you sit for long hours at a workstation, computer, or driving? Yes No

If yes, please explain _____

Do you perform any repetitive movement in your work, sports or hobbies? Yes No

If yes, please explain _____

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?

muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other _____

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

If yes, please explain _____

Do you have radiating pain? Yes No

If yes, please explain _____

Do you have any particular goals in mind for this session? Yes No

If yes, please explain _____

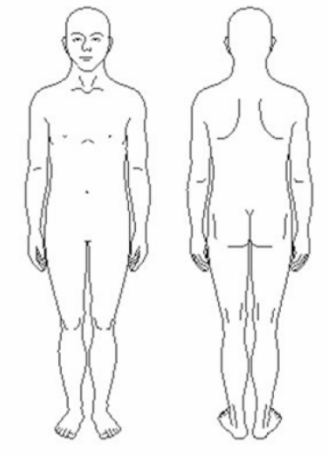
Do you exercise regularly? Yes No

If yes, please describe _____

What is your current pain level? 1 is least, 10 is most (circle) 0 1 2 3 4 5 6 7 8 9 10

When did you first notice your pain? _____

Please mark and label the diagram with aches, pains, numbness, or other problems.



X – Stabbing Pain
O – Numbness
//// - Aches
+++ - Pins and Needles
----Burning

In order to plan a session that is safe and effective, please answer the following question about your medical history.

Are you currently under medical supervision? Yes No

If yes, please explain _____

Do you see a chiropractor? Yes No

If yes, how often? _____

Are you receiving other alternative treatment? Yes No

If yes, please explain_____

Are you currently taking any medication? Yes No

If yes, please list _____

Please check any condition listed below that applies to you:

( ) contagious skin condition	( ) phlebitis (inflammation of a vein)
( ) open sores or wounds	( ) deep vein thrombosis (varicose veins) or blood clots
( ) easy bruising	( ) joint disorders-rheumatoid arthritis__,osteoarthritis__,tendonitis__
( ) recent accident or 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 problems
( ) high or low blood pressure	( ) carpal tunnel syndrome
( ) circulatory disorder	( ) tennis elbow
( ) atherosclerosis (cholesterol)	( ) pregnancy if yes, how many months? _____

Please explain any condition that you have marked above (use back if necessary) _____

_____

Is there any other information that would be useful in planning a safe and effective treatment session for you?

Please read and complete the following:

I,_____(print name) understand the treatment I receive is provided for the basic purpose of relief of muscular pain and tension and/or relaxation. If I experience discomfort during this session, I will immediately inform the therapist so that treatment may be adjusted as needed. I further understand that this treatment should not be construed as a substitute for medical examination, diagnosis and that I should see a physician, chiropractor or other qualified medical specialist for any spinal or skeletal adjustments, diagnosis, prescription, or to treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because trigger point and massage therapy 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 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.

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.

Signature of client or legal guardian _____ Date _____

It is understood that unexpected and emergency situations arise from time to time, however, the below policy will apply otherwise. Thank you for your understanding.

Cancellation Policy:
30 minute session - 24 hour. notice requested – 12 hour notice required or full amount of session is due. *
60 minute session - 48 hour notice requested – 24 hour notice required or full amount of session is due *
90 minute session - 72 hour notice requested – 48 hour noticed required of full amount of session is due. *

* If your appointment is filled, there will be NO charged for the canceled appointment.

Missed appointments: Every effort will be made to contact you via phone, email and text, if applicable. If there is no response, all future appointments will be canceled after 1 week.