CLIENT INTAKE INFORMATION

Name: _____ Referred By: _____

Address: _____ Birth Date: _____

City/State/Zip: _____ Email: _____

Phone: (H) _____(C)_____(W)_____

Occupation: _____ Primary Health Care Provider: _____

Emergency contact – Name/Relationship/Phone: _____

MASSAGE HISTORY/TREATMENT INFORMATION

Have you ever received a professional massage? ☐ Yes ☐ No If yes, frequency _____Date of last massage_____

What is your major reason for seeking massage therapy?_____

Is there any region of the body you wish to **not** be touched? _____

Are you currently seeing any other practitioners (Physician, Chiropractor, Acupuncture, Physical Therapist, etc.)?
☐ Yes ☐ No If yes, details:_____

_____

Would you like me to confer with with any of above-mentioned practitioners? _____

List stress reduction and exercise activities, including frequency. _____

_____

List current medications (including OTC painkillers/supplements/herbs etc.), and reason for taking. _____

_____

_____

PREVIOUS HISTORY

Please include year, treatment received, and outcome.

Major surgeries, accidents, injuries and hospitalizations (include sprains/strains/head injuries/broken bones):_____

_____

_____

_____

MEDICAL INFORMATION

Please mark with a 'C' if condition is current, and approx. year(s) if in the past.

_____ bone or joint disease
_____ tendinitis/-osis
_____ arthritis
_____ low back, hip, leg pain
_____ neck, shoulder, arm pain
_____ headaches
_____ spasms/cramps
_____ jaw pain/TMJ disorder
_____ numbness/tingling
_____ chronic pain

_____ cancer/tumors
_____ diabetes
_____ heart condition
_____ varicose veins
_____ high/low blood pressure
_____ lymphedema
_____ respiratory problems
_____ fatigue/sleep disorders
_____ depression
_____ autoimmune condition

_____ allergies
_____ rashes
_____ athletes foot
_____ warts
_____ digestive problems
_____ herpes/shingles
_____ pregnant? Stage_____
_____ eating disorders
_____ drug/alcohol addiction
_____ nicotine/caffeine addiction

Details about above conditions or additional medical conditions/concerns? _____

_____

_____

_____

Consent Form

Liz Stefany, Licensed Massage Therapist
ME License # MT4220

- It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow.
- I understand that licensed massage therapists do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations.
- I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.
- If I experience any pain or discomfort during this or future massage therapy session(s), I will immediately inform the practitioner so that the pressure and/or techniques may be adjusted to my comfort level.
- I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for full payment for the scheduled appointment.
- I understand that bodywork is contraindicated under certain medical conditions and I will update the massage therapist of any changes in my medical profile. I understand that there will be no liability on the practitioner's part should I fail to do so.
- I have accurately stated all current and past medical conditions of which I am aware on this intake form.

Client Signature:_____ Date:_____

CONSENT TO TREATMENT OF A MINOR: I hereby authorize the above-named practitioner to provide my minor child/person under my guardianship with therapeutic massage as deemed appropriate to treat presenting conditions/injuries. I understand that I am financially responsible for the minor, and that all statements contained in this consent apply equally to me and to the minor.

Parent/Guardian Name: _____

Parent/Guardian Signature:_____ Date:_____

My child/charge has my permission to appear for treatment in my absence: _____Initials_____