

Massage Therapy Client Intake Form

Name:	Date of Birth:
Address:	City/State/Zip:
Phone:	eMail:
Occupation:	Referred By:
Emergency Contact:	Emergency #:

Have you experienced a professional massage or bodywork session? ____ Yes ____ No
How much water do you drink daily?
List activities and frequencies of sports, musical instruments, hobbies that you enjoy:
List current medications and/or supplements:
List current and previous accidents, injuries, surgeries:
List primary area of complaint:
What is your goal in seeking this type of treatment:

Other Concerns:

MUSCULO-SKELETAL

- Neck / Shoulder / Arm Pain
- Jaw Pain / TMJ
- Low Back / Hip / Leg Pain
- Broken / Fractured Bones
- Osteoporosis / Arthritis
- Spasms / Cramps
- Numbness / Tingling
- Bulging Disc
- Herniated Disc
- Degeneration, Prolapse, Extrusion, Sequestration
- Spinal Stenosis
- Spondylolisthesis grade level 1 2 3 4

REPRODUCTIVE

- Pregnant _____ weeks

RESPIRATORY

- Breathing Difficulty / Asthma
- Sinus Condition
- Virus / Contagious Disease

DIGESTIVE

- Constipation / Diarrhea
- Acid Reflux
- Irritable Bowel Syndrome
- Diabetes
- Depression / Anxiety

NERVOUS

- Herpes / Shingles
- Fatigue / Sleep Disorder
- Seizure Disorder

CIRCULATORY

- Heart Condition
- Varicose Veins
- Blood Clots
- High / Low Blood Pressure
- Edema / Swelling
- Stroke

SKIN

- Eczema / Psoriasis / Rash
- Athlete's Foot / Warts

OTHER

- Headaches
- Cancer / Tumors
- Implants



PLEASE READ AND SIGN:

Massage Therapy is provided for the basic purpose of relaxation, stress reduction and relief of muscular tension. Massage Therapy services are designed to be a health aid and in no way are meant to take the place of a physician's care. Information exchanged during a massage therapy session is educational in nature and is intended to help the client become more familiar and conscious of his/her own health status and is to be used at his/her own discretion.

Because massage therapy should not be performed under certain medical conditions, I (the client) affirm that I have stated all my known medical conditions and answered all questions honestly, and I understand that it is my responsibility to keep the massage therapist updated as to any changes in my medical profile.

I (the client) also understand that any illicit or sexually suggestive remarks or advances made by me toward the massage therapist will result in immediate termination of the session.

LATE POLICY:

A phone call or text is appreciated should you find yourself running late. Please note that your arrival time will determine the length of the session, which will end as scheduled so as not to inconvenience the next client.

CANCELLATION POLICY:

Your treatment sessions are reserved exclusively for you. I value your business and ask that you respect the following scheduling policy. Should you need to cancel or reschedule, please notify me immediately. Cancellation with less than 24-hour notice prevents me from accommodating other clients and is subject to a cancellation fee of \$120 (60-minutes) or \$170 (90-minutes).

I recognize that there are circumstances that are out of your control. If an emergency situation arises (such as sudden illness or family emergency), please let me know so that I can treat your specific situation with personal attention.

By scheduling a session with Collective Balance and by signing below, you acknowledge the communication of this cancellation policy and fee.

PAYMENT OPTIONS:

Payment is due when services are rendered, unless other arrangements have been made prior to the appointment, and are payable via cash, check, or credit card.

Signature:	Date:
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