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

COLLECTIVE BALANCE

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 1 business day notice prevents me from accommodating other clients and is subject to a cancellation fee of $120.

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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