The Good Life Massage – Client Intake Form

Please print legibly

Name: _____ Email: _____

Address: _____ City, ST Zip: _____

Preferred phone: _____ Birthday: _____

Referred to this office by: _____ Occupation: _____

Emergency contact: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Massage/Bodywork Information

On a scale from 1 to 10, 10 = highest, rate your average levels of:

Stress: _____ Pain: _____ Energy: _____

How did your symptoms begin & when did they start? _____

Is your condition getting better/worse? _____

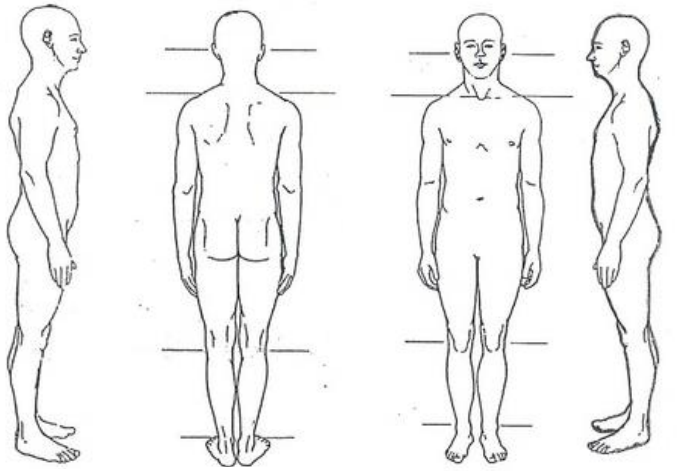
What have you done for relief? _____

What your massage or bodywork goals? _____

What kind of pressure do you prefer?

☐ Light
☐ Medium
☐ Firm
☐ Deep

On the diagrams to the right, mark any areas where you are experiencing tension (T), pain (P) and/or discomfort



General/Medical Information

Y N Have you ever had a professional massage? If yes, how often? _____

Y N Are you pregnant? If yes, how far along are you? _____ **Additional form required*

Y N Are you sensitive to touch/pressure in any area? Ticklish? Bruise easily? _____

Y N Do you have sensitive skin or allergies (essential oils, nut oils, fragrances etc.)? If yes, please list: _____

_____

List of current medications we should know about: _____

_____

List accidents/injuries within the last years (Surgeries, whiplash, sprain, other): _____

_____

_____

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Medical Info (cont.) – Please check all that apply:

- ☐ Skin condition – Rash, warts, hives, skin cancer, other: _____
- ☐ Lymphatic condition – Swollen gland, lymph edema, Chronic congestion:_____
- ☐ Joint issues – Stiffness, Arthritis, sacroiliac problems, TMJ, other: _____
- ☐ Bone condition – Osteoporosis, fracture, other: _____
- ☐ Headaches – Type & Frequency:_____
- ☐ Major surgeries – Type and Date:_____
- ☐ Circulatory condition– Varicose veins, blood clots, high blood pressure (Are you taking medication?):_____

  _____
- ☐ Numbness/tingling, Nerve disorders:_____
- ☐ Tendinitis, tendinosis or bursitis: _____
- ☐ Diabetes: _____
- ☐ Epilepsy/Seizures: _____
- ☐ Contagious diseases: _____
- ☐ Other medical conditions/medications we should know about? _____

Massage Client Waiver

Please take a moment to read and initial all of the following statements:

If I experience pain or discomfort during the session, I will immediately inform my Licensed Massage Practitioner (LMP) so that pressure/strokes can be adjusted to my level of comfort. I will not hold my LMP responsible for any pain or discomfort I experience during or after the session. _____

I understand that the services offered today are not a substitute for medical care. I understand that my LMP is not qualified to perform skeletal adjustments, diagnose, prescribe or treat physical or mental illness. I affirm that I have notified my LMP of all known medical conditions and injuries._____

I agree to inform my LMP of any changes in my health/medical condition. I understand that there shall be no liability on the LMP's part should I forget to do so. By signing this release, I hereby waive & release my LMP from any liability past, present and future relating to massage therapy and bodywork._____

I understand that massage is entirely therapeutic and non-sexual in nature. I also understand that any illicit or sexually suggestive remarks or advances I make will result in immediate termination of the session, and I will be liable for payment of the appointment._____

I understand that if I cancel my session between 24 and 4 hours prior to my appointment, I'll be charged 50% of the cost of the massage. If I forget or choose to miss my appointment, or call to cancel less than 4 hours prior to my session start time, I will be charged the full value of the massage. If I do need to cancel my session, I'll try to do so more than 24 hours prior to my appointment time to avoid any charges. _____

I understand that I can request a copy of my records at any time per the Health Insurance Portability & Accountability Act (HIPAA). Requests will be granted within 30 days of written notice and a nominal fee may be charged for copying requested records. Everything discussed with my LMP is confidential and cannot be discussed with anyone unless I provide written consent. _____

Client Signature:_____ Date: _____

LMP Signature:_____ Date: _____