That Massage Place

Professional Massage Therapy

241 Freeport Road
Aspinwall, PA 15215

CLIENT INFORMATION & INTAKE

Name: _____ Date of Birth: _____
Phone: _____ Emergency Contact: _____
Email: _____ Phone: _____

HEALTH & MEDICAL HISTORY

Are you taking any prescribed medications, blood thinners, or OTC pharmaceuticals?

_____

_____

Do you have any known allergies? _____

_____

Are you currently experiencing:

- ☐ Pregnancy
- ☐ Numbness / Tingling
- ☐ Headaches / Migraines
- ☐ Arthritis / Tendonitis
- ☐ Muscle Sprains / Strains
- ☐ Skin Conditions
- ☐ Contagious or Fungal Infections

Have you ever been diagnosed with or been advised to seek treatment for:

- ☐ High / Low Blood Pressure
- ☐ Blood Clots / Varicose Veins / Stroke
- ☐ Respiratory Conditions / Asthma
- ☐ Spinal / Bone Disorders
- ☐ Nerve Disorders / Seizures
- ☐ Damaged or Removed Lymph Nodes
- ☐ Cancer
- ☐ Anxiety / Depression
- ☐ Do you have any other conditions not mentioned above, or wish to provide more detail about a condition?

_____

_____

_____

_____

Have you:

- ☐ Had Surgery
- ☐ Had Accidents or Trauma
- ☐ Broken or Dislocated any Bones
- ☐ Received Medical Hardware or Implants

If yes, please explain including when: _____

_____

_____

_____

_____

MASSAGE HISTORY

Have you received therapeutic massage before? Yes / No

Do you have any specific likes or dislikes regarding massage?

_____

_____

What is your occupation? _____

What stresses do you put on your body the most often?
Examples include: work, sports, hobbies or being sedentary:

_____

_____

_____

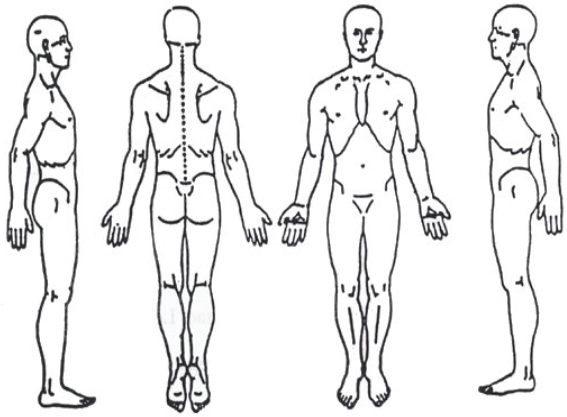
_____

What are your goals in receiving massage?

_____

_____

Please circle any areas on the body below where you are experiencing pain, tension, etc.



What level of pressure will be most comfortable to you?

Lighter _____ Moderate _____ Heavier

Therapist's Notes: _____

_____

_____

_____

_____

PLEASE READ AND SIGN:

Massage is provided for the basic purpose of relaxation, stress reduction, and relief of muscular and soft tissue tension. Massage services are designed to be a health care aid and in no way are meant to take the place of a physician's care. Information exchanged during a massage session is educational in nature and is intended to help broaden awareness and not to treat, diagnose, or cure any condition.

I affirm that I have stated all of my known medical conditions and answered all questions honestly. I understand that it is my responsibility to keep the massage therapist updated as to any changes in my medical profile.

I also understand, and agree without exception, that:

- Illicit or sexually suggestive remarks or advances made by me may result in the immediate termination of the session, at my therapist's sole discretion, and full payment for the scheduled appointment will be due.
- Payment is due when services are rendered unless other arrangements have been made prior to my appointment.
- I will give 24 hours notice if I cannot keep an appointment. I understand I may be charged for canceling without sufficient notice. With this policy in mind, I also understand that it is not safe for myself or my therapist to receive massage while in the acute infection period of viruses or bacteria, and will communicate with my therapist at my first convienence should I become ill and unable to keep an appointment.

Signature: _____ Date: _____

Evaluated By Therapist: