

Massage Therapy Intake Form

Name _____ Date _____

Address _____
Street City State Zip

Date of Birth _____ Home Number _____ Cell Number _____

Emergency Contact _____
Name Relationship Number

Are you presently taking any medication? _____ Yes _____ No

Please Explain:

Have you had a recent major surgical procedure or injury? _____ Yes _____ No

Please Explain:

Are you currently seeing a Chiropractor, Physical Therapist, or Physician for an ongoing issue?

_____ Yes _____ No

Please Explain:

Please circle your stress level:

Low 1 2 3 4 5 High

Please circle desired massage: Swedish Deep Tissue Cupping Reflexology Hot Stone

Please circle desired pressure: Soft Medium Hard

Are you allergic to any Lotions or Oils? _____ Yes _____ No

Please Explain: _____

Circle the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

- Headaches
- Joint stiffness/swelling
- Spasms/cramps
- Broken/Fractured bones
- Strains/Sprains
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Leg, foot pain
- Chest, ribs, abdominal pain
- Problems walking
- Jaw pain/TMJ
- Tendonitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Other: _____

Circulator/Respiratory

- Dizziness
- Shortness of breath
- Fainting
- Cold feet or hands
- Cold sweats
- Stroke
- Heart condition
- Allergies
- Asthma
- High blood pressure
- Low blood pressure
- Other: _____

Digestive

- Indigestion
- Constipation
- Intestinal gas/bloating
- Diarrhea
- Irritable bowel syndrome
- Crohn's Disease
- Colitis
- Other: _____

Nervous System

- Numbness/tingling
- Fatigue
- Sleep disorders
- Ulcers
- Paralysis
- Herpes/shingles
- Cerebral Palsy
- Epilepsy
- Chronic Fatigue Syndrome
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's Disease
- Other: _____

Reproductive System

- Pregnancy

Skin

- Rashes
- Allergies
- Athlete's foot
- Acne
- Impetigo
- Hemophilia

Other

- Loss of Appetite
- Depression
- Difficulty concentrating
- Hearing Impaired
- Visually Impaired
- Diabetes
- Fibromyalgia
- Post/Polio Syndrome
- Cancer
- Tuberculosis
- Other: _____

I understand that a massage Therapist does not diagnose disease, illness, or prescribe any treatment or drugs, nor do they provide spinal manipulation. I understand that draping will be used at all times and that breast massage will not be administered on female clients. I understand that if I become uncomfortable for any reason that I may ask the Therapist to end the massage session, and they will end the session. I understand that the massage Therapist may end the session for any inappropriate behavior. I have stated all of the conditions that I am aware of, and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's signature _____ Date _____

Consent for Therapy and Waiver of Liability

The undersigned ("Client") hereby freely consents to receipt of massage services from:

Licensed Massage Therapist's Name

Client agrees as follows:

Client understands and agrees that they will provide the Therapist with complete and accurate health information, and a written referral from Client's primary healthcare provider if Client is currently receiving care or has a specific medical condition or symptoms for which Client takes medication or receives periodic evaluations or treatment. Client understands that massage therapy is designed to be an ancillary health aid and is not suitable for primary medical treatment for any condition.

1. Client and Therapist have discussed the potential benefits and possible side effects of massage therapy and have agreed upon a course of focused attention and manually therapy for the predetermined goals of stress reduction, relief of muscular discomfort, and/or promotion of general health. Client has been given an opportunity to ask questions of the Therapist and has received all requested information.
2. Client understands that the unclothed body will be draped at all times for warmth, sense of security, and as a mark of massage therapy professionalism. Client agrees to immediately inform the Therapist of any unusual sensation or discomfort so that the application of pressure may be adjusted to Client's level of comfort. Client understands that massage therapy is not sexual in any manner and that any illicit or suggestive remarks or behavior on the client's part, will result in an immediate termination of the therapy session. Client understands that payment will be expected in full; regardless if the massage is completed or not.
3. Client hereby assumes fully responsibility for receipt of the massage therapy, and releases and discharges Therapist from any and all claims, liabilities, damages, actions, or causes of action arising from the therapy received hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the Therapist, to the fullest extent allowed by law.
4. Client, in signing this consent for Therapy and Waiver of Liability ("Consent"), understands and agrees that this Consent will apply to and govern the current and all future therapy sessions performed by Therapist

Client Signature

Client Printed Name

Date

Massage Therapist Signature

Massage Therapist Printed Name

Date



NOTIFICATION CONSENT:

Notaro Chiropractic will now be sending reminder texts and calls for your convenience on upcoming appointments as friendly reminders.

Notaro Chiropractic will also be sending emails monthly for our new monthly promotions on supplies.

*By signing this form, you agree to receive text messages, phone calls and emails regarding appointments and promotions from Notaro Chiropractic, its management company Chiropractic Office Solutions, agents, contractors, and assignees.

Thank you.

Signature: _____

Date: _____