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4E John Tyler St.
Merrimack, NH 03054

Massage Client Intake Form

PLEASE PRINT LEGIBLY

Name _____ Email _____
Address _____ City/State/Zip _____
Phone: Home_____Work_____Cell_____ Birthday ___/___/___
Occupation _____ Referred to This Office By _____
In Case of Emergency Please Contact _____Phone_____

General and 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? _____

Y N Are you sensitive to touch/pressure in any area? (ticklish?) _____

Y N Are you allergic or sensitive to any oils (essential oils, nut oils, scents)? If yes, please list:

_____

List of current medications and reason: _____

_____

_____

List of surgeries (type and date): _____

_____

_____

Indicate Areas of Pain/Tension:

On a scale from 1-10, 10=highest, rate your levels of:
Stress _____ Pain _____ Energy _____
How did your symptoms begin and when did they start?

_____

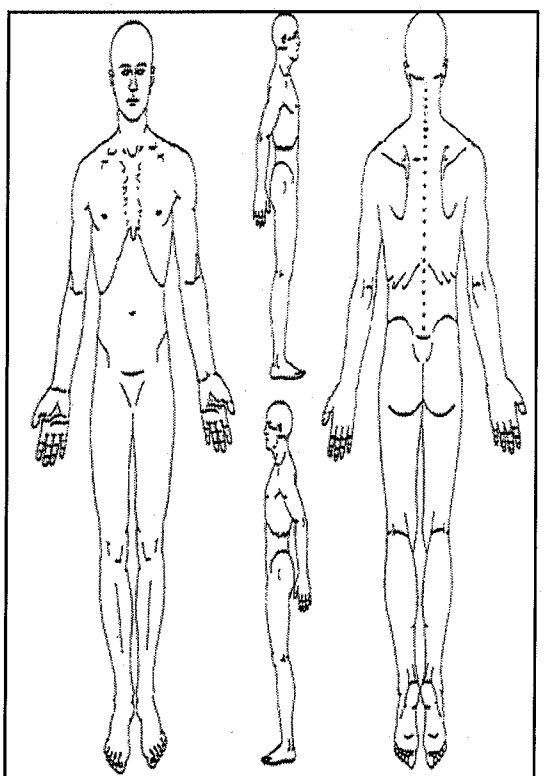
_____

What have you done for relief? _____

Is the condition getting better/worse? _____

Please check all that apply:

- ❑ Skin condition-rash, warts, hives, skin cancer, other _____
- ❑ Lymphatic condition-swollen gland, nasal congestion, lymph edema
- ❑ Joint problems/stiffness-arthritis, sacroiliac problems, TMJ, other
- ❑ Bone Condition-osteoporosis, fracture, other _____
- ❑ Headaches
- ❑ Recent injury or accident-whiplash, sprain, bruise, other _____
- ❑ Circulatory Condition-high blood pressure, varicose veins, blood clots
- ❑ Numbness/Tingling, Sciatica
- ❑ Tendonitis, Bursitis
- ❑ Diabetes



Please mark in the diagram above any areas where you have pain or discomfort.

Client Agreement and Health Release Form

Client Agreement

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage therapy and give my consent for massage. I understand that there is no implied guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I am aware that there is a $50 charge for appointments cancelled less than 24 hours before scheduled appointment and if I do not call or show up, I am responsible to pay for the full session. I am aware that until my bill is paid in full, I will not be able to schedule further appointments.

Signature _____ Date _____

Release of Medical Records

I authorize the release of medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys, health care providers, and insurance case managers, for the purposes of processing my claims.

Signature _____ Date _____