CLIENT INTAKE FORM – MASSAGE THERAPY AND LYMPHATIC DRAINAGE

Personal Information

Name: ____ Today's Date: __________ Birthdate: _________

Street Address: ____ City/Zip: ______________________

Phone: _____________________ Email: ______________________ Referred By: ________________________

Emergency Contact Name: _____________________ Relationship: ___________ Phone: __________________

Medical Information

Do you suffer from pain? Yes _____ No _____

Is it chronic? Yes _____ No _____

How long has it occurred? ____________________

Are there things that make it worse? ___________

____

Have you had a recent medical procedure?

Yes _____ No _____

If yes, describe:_____________________________

____

Do you have any current injuries:Yes _____No ____

If yes, describe: _____________________________

____

Are you pregnant: Yes _____ No _____

Please indicate if any of these apply to you:

_____Cancer: ___________ _____ Fibromyalgia

_____Headaches/Migraines _____ Stroke

_____Sprains/Strains ______Heart Attack

_____ Joint Replacement ______ Blood Clots

_____High/low blood pressure _____Neurophathy

_____ Incision issues _____ Lymphedema

_____ Numbness/tingling _____ Arthritis

Bodywork Information

Have you had a massage before? Yes ___ No ____

What type of bodywork are you looking for?

_____ Therapeutic Massage _____ Lymphatic

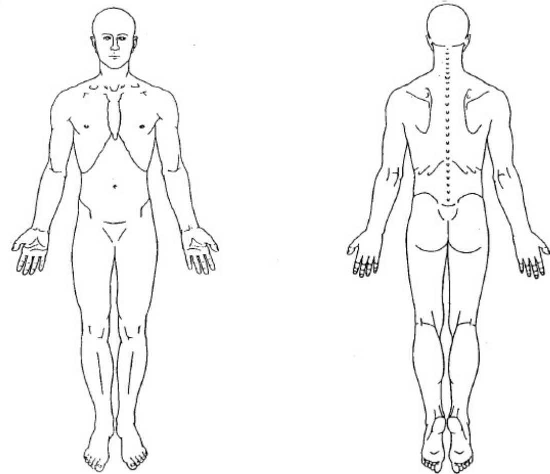
Do you have any skin allergies to lotions or oils?

____

Are there areas of your body you want to avoid?

____

Please mark an "x" in areas of discomfort:



Is there any other condition you want your massage therapist to be aware of? _____________

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General Liability Release for Massage Services:

I give my permission to receive massage therapy. I understand that therapeutic massage is not a substitute for traditional medical treatment or medications. I understand that the massage therapist does not diagnose illnesses or injuries, or prescribe medications. I have clearance from my physician to receive massage therapy. I understand the risks associated with massage include, but are not limited to: superficial bruising, short-term muscle soreness, and exacerbation of undiscovered injury. I therefore release Gina Perine Medical Massage and the individual massage therapist from all liability concerning these injuries that may occur during the massage session. I understand the importance of informing my massage therapist of all medical conditions and medications I am taking, and to let the massage therapist know about any changes to these. I understand that there may be additional risks based on my physical condition. I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so he/she may adjust accordingly. I understand that I or the massage therapist may terminate the session at any time. I have been given a chance to ask about the massage therapy session and my questions have been answered.

Print Name: ____

Signature: ____

Date: ________________________________