Angel Light Holistic Healing

Client Intake Form – Therapeutic Massage

Name_____ Phone (Day) _____Cell_____

Address_____City/State/Zip_____

Email_____ Occupation _____

Date of Birth_____ Referred by _____

Emergency Contact _____ Phone_____

The following information will be used to help your therapist plan a safe and effective massage session. Please answer the questions to the best of your knowledge.

Have you had a professional massage before? Yes No If yes, how often? _____

Do you have any difficulty lying on your front, back, or side? Yes No

If yes, please explain _____

Do you have any allergies to oils, lotions, ointments, fruits or nuts? Yes No

If yes, please explain _____

Do you have sensitive skin? Yes No

Are you wearing contact lenses, dentures, a hearing aid, or prosthetics? _____

Do you sit for long hours at a workstation, computer, or driving? Yes No

If yes, please describe _____

Do you perform any repetitive movement in your work, sports, or hobby? Yes No

If yes, please describe _____

How do you feel the stress in your work, family, or other aspect of your life affected your health?

muscle tension anxiety insomnia irritability other_____

Is there a specific area of the body where you are experiencing tension, stiffness, pain or discomfort?

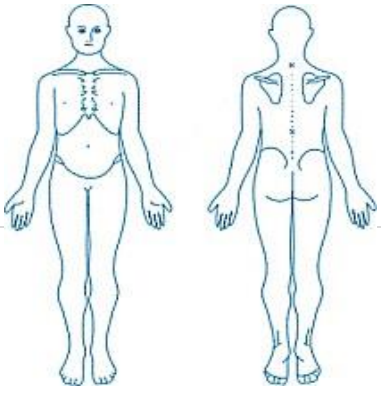
Yes No If yes, please identify_____

Do you have any particular goals in mind for this massage session? Yes No

If yes, please explain_____

Circle any specific areas you would like the massage therapist to concentrate on during the session:

Medical History



Do you currently or have you ever had any of the following: (please check)

_phlebitis
_ tennis elbow
_deep vein thrombosis/blood clots
_recent fracture
_ joint disorder
_recent surgery
_ rheumatoid arthritis/osteoarthritis/tendonitis
_artificial joint
_osteoporosis
_sprains/strains
_epilepsy
_current fever
_headaches/migraines
_swollen glands
_allergies/sensitivity
_diabetes
_ decreased sensation
_ high or low blood pressure
_ back/neck problems
_ circulatory disorder
_ Fibromyalgia
_ varicose veins
_ TMJ
_ Atherosclerosis
_ carpal tunnel syndrome
_ easy bruising
_ contagious skin condition
_ recent accident or injury
_ open sores or wounds
_ pregnancy If yes, how many months
_cancer
_heart condition

Are you currently under medical supervision? Yes No

If yes, please explain_____

Do you see a chiropractor? Yes No If yes, how often?_____

Are you currently taking any medication? Yes No

If yes, please list _____

Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you? _____

_____

_____

Would you like to be put on my email list for special offers and promotions? Yes No

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given

should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____