Confidential Client Intake Form

In order to maximize the effectiveness and safety of your massage sessions please carefully read and fill out the following questionnaire. This information WILL be treated confidentially. Your feedback is appreciated during, and at the end of the massage session to help serve you in the best way possible.

Name: ______________________________ Date: ______________

Address: ______________________________ City:__________ State:_____ Zip________

Phone (Home): ______________ Phone (cell):______________ DOB:____________

Occupation:______________________________ Employer:______________

Referred by: ______________________________ Physician: ______________

Previous experience with massage therapy:

____

Primary reason for appointment/ areas of pain or tension:

____

Emergency Contact- Name:______________________ Phone:______________________

Please mark (X) for all conditions that apply now. Mark (P) for past conditions. Mark (F) for family history of illness.

Pain Scale: Minor- 1 2 3 4 5 6 7 8 9 10-Severe

____ Heart disease, strokes
____ Circulatory problems, blood clots
____ High/low blood pressure
____ Headaches, Migraines
____ Vision problems
____ Hearing impairments
____ Jaw pain, TMJ
____ Immune disorders
____ Infectious diseases
____ Herpes I or II
____ Hepatitis A, B, or C
____ Abdominal or digestive problems
____ Dizziness, fainting spells
____ Abscess or Open sores
____ Allergies, sinus problems
____ Rash or skin sensitivities
____ Fatigue, stress, tension
____ Depression
____ Sleep difficulties
____ Asthma or any other lung condition
____ Muscle or joint pain
____ Muscle, bones injuries
____ Sprains, strains
____ Osteoporosis
____ Any form of Arthritis
____ Herniated Disk
____ Fibromyalgia
____ Whiplash
____ Numbness or tingling
____ Hernias
____ Epilepsy
____ Cerebral Palsy
____ Cancer, tumors
____ Diabetes
____ Hormone Therapy
____ PMS, Painful menstruation
____ Varicose Veins
____ Psoriasis, Eczema
____ OTHER: ____

____

____

____

(Please turn over)

Have you ever had surgery? (When?, explain):

____

____

Have you ever been in any accidents? (When?, explain):

____

____

Do you wear contacts? ____________ Dentures?____________ Hearing Aid?______________

Are you currently under medical care or supervision?______________________
For what condition?______________________

Is there any other health information you think would be beneficial for your massage therapist to know?

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Massage Client Waiver

Please take a moment to read the following information:

- I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, improvement of circulation, and energy flow.
- I understand that a massage is entirely therapeutic and non-sexual in nature, and am fully aware that the therapy can be stopped at anytime if any code of ethics is violated.
- If I experience pain or discomfort during the session I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
- I understand that I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problem. I also understand it is my responsibility to keep my massage therapist informed of any changes in my health and medications.
- By signing this release, I hereby waive and release my therapist from any and all liability, past, present and future relating to massage therapy and bodywork.
- I understand I will be responsible for payment at the time services are rendered.

Information and Suggestions

- Prior to your massage, please remove gum, glasses, and all jewelry.
- In general, massage is given while you are unclothed. However, you may choose to wear wear undergarments. You will be covered with a top sheet throughout your session. This is your massage and you should be as comfortable as possible.
- Feel free to ask your therapist any questions before, during, or after the session. Your therapist is a highly trained professional and will be happy to make you feel informed and comfortable.

I have received the policy statement, and have read and agree to the policies therein. I give the Circle City Chiropractic massage therapist permission to treat me with massage therapy.

Client Name (printed): ______________________________

Client Signature: ______________________________ Date: ____________