Client Massage Health Intake

Heather James, LMBT #10296

Name:____DOB:_____________________

Address:____

Email:____Tel:_____________________________

Occupation:________________________________Referred by:________________________

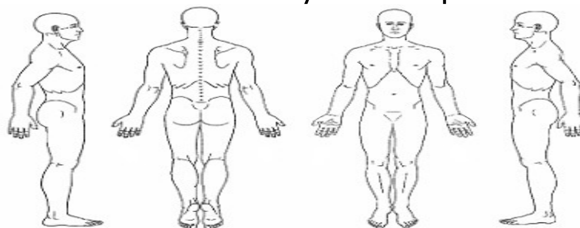
Have you ever had professional massage? Yes___ No___ Last massage:_________________

Have you ever experienced any of the following? If so, please explain and include dates.

Allergies:____
Surgery:____
Injuries:____
Skin Conditions:____
Chronic Conditions:____
Cancer:____
Diabetes:____
Stroke:____
Heart Conditions:____
Fibromyalgia:____
Open wounds/infections:____
Varicose Veins:____
Swelling/Clotting Issues:____
Medications:____
Other:____

Are you pregnant? Yes___ No___ How many weeks?______ Breastfeeding? Yes___ No___
Goals for today's session:____
____

Please indicate on the figures the areas where you need pain relief and/or extra attention:



I,______________________, agree, since there are some medical conditions in which massage should not be performed, that all information is true, that I have indicated all medical conditions/medications, that I will advise my therapist if anything changes or if any discomfort/pain is experienced during the course of the massage. I understand that service is provided for the purpose of relaxation/relief of muscular tension and is NOT a substitute for medical examination, treatment, or diagnosis. The therapist and client both have the right to terminate the massage at any time. All services are non-sexual and therapeutic in nature. I understand that Heather James, LMBT #10296 requires 24 hours for all cancellations and reschedules. Missed and canceled appointments will be charged to the credit card on file 50% of the scheduled service.

Signature:____Date:_______________