

# WILLIAMSTON WELLNESS, PLLC

## MASSAGE INTAKE FORM



Today's Date \_\_\_\_\_

### PATIENT INFORMATION:

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M F T

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email \_\_\_\_\_ Ok to receive reminders via (circle) text email both

Occupation \_\_\_\_\_ Employer or School Name \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_ Phone \_\_\_\_\_ Last Seen \_\_\_\_\_

### MASSAGE INFORMATION:

How did you hear of us? If by referral, please list name \_\_\_\_\_

Have you ever had a professional massage before?  Yes  No If so, how long ago \_\_\_\_\_

What type of massage are you seeking?  Relaxation  Therapeutic/Deep Tissue  Prenatal  Hot Stone

What pressure do you prefer?  Light  Medium  Deep  Other \_\_\_\_\_

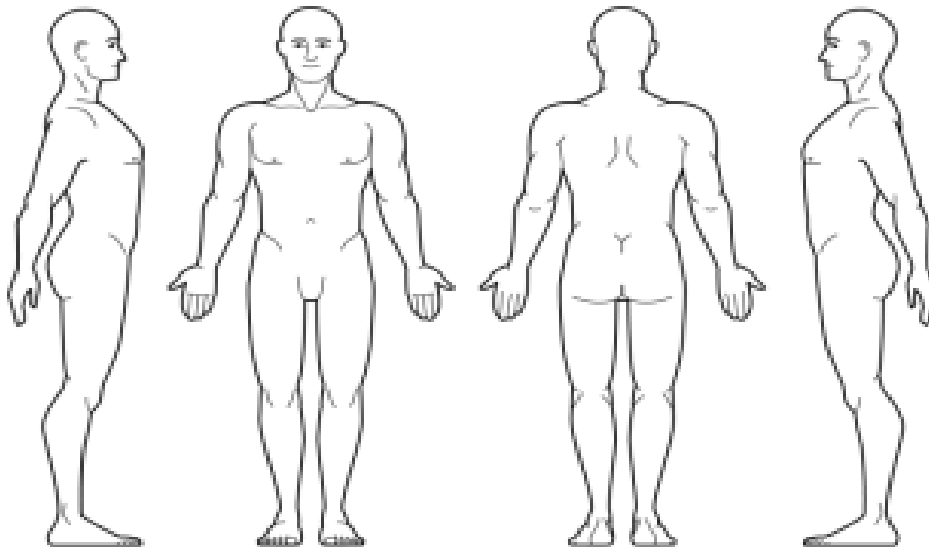
Are you sensitive to fragrances or perfumes?  Yes  No Do you wear contact lenses?  Yes  No

Do you exercise regularly?  Yes  No If yes, what type(s)? \_\_\_\_\_

What are your common areas of pain or tension? \_\_\_\_\_

Are there any areas you do NOT want massaged? \_\_\_\_\_

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



**MEDICAL HISTORY:**

Are you taking any medications?  Yes  No If yes, please list\_\_\_\_\_

Have you been hospitalized for any reason in the past 6 months?  Yes  No If yes, please explain\_\_\_\_\_

Have you had any recent injuries or illnesses?  Yes  No If yes, please explain\_\_\_\_\_

Do you see a chiropractor or other healthcare specialist?  Yes  No If yes, for what?\_\_\_\_\_

Are you currently pregnant?  Yes  No If yes, how far along?\_\_\_\_\_ Any risk factors?  Yes  No  
If any risk factors, Please explain\_\_\_\_\_

Please indicate any conditions that you have had or currently have:

- Frequent Headaches  Migraines  Allergies  Arthritis  Tendonitis  Cancer, tumors  TMJ problems
- Skin condition  Heart/circulation problems  Joint replacement  High / low blood pressure  Blood clots
- Muscle weakness  Varicose veins  Miscarriages  Neck / back injuries  Diabetes  Auto Accident
- Fibromyalgia  Numbness  Sprains, Strains  Neuropathy  Recent illness  \_\_\_\_\_

Explain any conditions that you have marked above or others not listed:\_\_\_\_\_

**PATIENT ACKNOWLEDGEMENT & CONSENT:** By signing below, you agree to the following:

- I have completed this form to the best of my ability and knowledge. 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 therapeutic massage is not a substitute for medical treatment or medications and that the massage therapist does not diagnose illnesses or injuries, or prescribe medications.
- I understand the risks associated with massage therapy include, but are not limited to: Superficial bruising, Short-term muscle soreness and exacerbation of undiscovered injuries. I therefore release the company and the individual massage therapist from all liability concerning these injuries that may occur during the massage session.
- 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 understand that sexual advances and other verbal or physical conduct of a sexual nature will not be tolerated, resulting in immediate termination of the session and I will be liable for payment of the scheduled treatment.
- I agree to abide by a 24 hour cancellation notice for any scheduled massage. I understand that I may be charged for missed appointments or for any cancellations with less than a 24 hour notice. I understand that if I arrive late for an appointment, the session will end at the original scheduled time. However, if the massage therapist is late, she will fulfill the scheduled massage length or offer a reasonable compensation.
- I give my permission to receive massage therapy.

Client Signature\_\_\_\_\_ Date\_\_\_\_\_