

Client Intake and Informed Consent Form

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone #: _____ Evening Phone #: _____

Email Address: _____

Date of Birth: _____ Sex: _____

Occupation: _____ Employer or School: _____

Have you had a professional massage before? No Yes (if yes, how long ago?) _____

In Case of Emergency, Please Notify:

Name: _____ Telephone #: _____

Relationship: _____

I, _____, (client) understand that massage therapy provided by Jonathan Drummey (massage therapist) is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, improve body awareness, increase sense of well-being, and offer a positive experience of touch. Any other intended purposes for massage therapy are specified below:

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Health Care Provider for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

Client (or Guardian) Signature

Date

(please continue to other side if we will be billing insurance)

Client Health Information Sheet

Name: _____ Date: _____

Present symptoms: What is your major complaint or condition you want to improve? _____

When did you first notice major complaints? _____

What brought it on? _____

What activities aggravate the condition? _____

Is this condition getting progressively worse? No Yes

Please explain: _____

Does this condition interfere with work? N Y Sleep? N Y Daily Routine? N Y

Please explain: _____

What have you done to get relief? _____

Has there been a medical diagnosis? No Yes (if yes, by whom?) _____

Please Explain: _____

Have you had X-rays taken? No Yes (if yes, by whom?) _____

List any current medications: _____

List any allergies: _____

Please check any of the following conditions that apply to you, past and present.

Skin problems Arthritis High/low blood pressure

Blood clots Diabetes Varicose veins

Seizures Cancer Contagious diseases

Contact lenses Circulation disorders Pregnant (or trying to)

Add any additional information on these issues here: _____

(continued on other side)

Please list (date and description) any accidents and operations, and other major life trauma: ___

Describe the exercise activities you do (include frequency): _____

List other therapies you receive: _____

Please list any additional comments regarding your health and well-being: _____

What are your intentions or expectations for this visit? _____

On these diagrams please **circle** the areas of your body that need the most attention in the massage session, and place an **x** over the areas that you wish to have avoided.

