



Massage Intake Form

Date _____ Date of Birth _____ Gender Male Female
Name _____ Member # _____

(If you are not a member of the University Club, please complete the following information)

Address _____
City _____ State _____ Zip Code _____
Phone: _____ Other _____
Email Address _____ Referred By _____
Emergency Contact _____ Emergency Contact Phone _____
Occupation _____

Medical Background

Please list any health conditions you are currently experiencing: _____

How often do you exercise? _____
What is your stress level? Low 1 2 3 4 5 6 7 8 9 10 High
How many hours of sleep do you get per night? _____
How many 8 oz. glasses of water do you drink a day? _____
How many ounces of caffeine do you consume each day? _____
Do you smoke? Yes No
Have you ever had a professional massage? _____
Do you suffer from frequent headaches? _____
Please list all supplements, medications, allergies or recent surgeries: _____

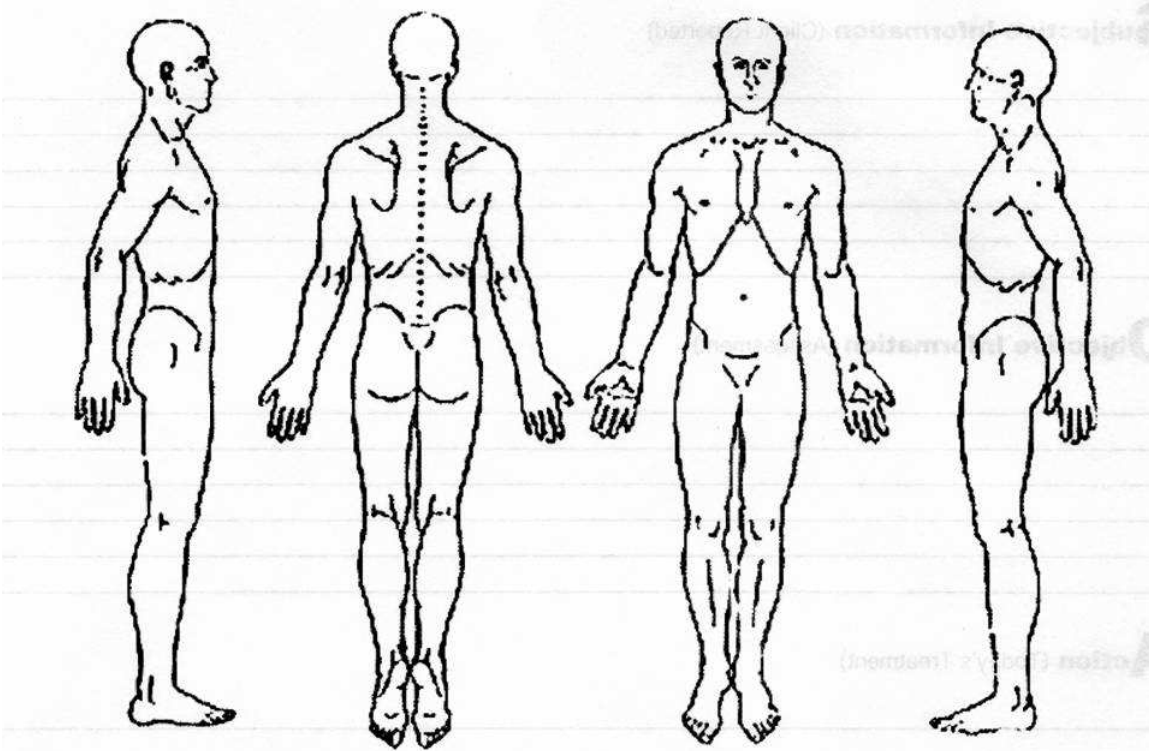
Client Self Assessment

Please check any condition listed below that applies to you:

- | | | |
|---|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stabbing Pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Cardiac problems | <input type="checkbox"/> Recent Surgery |
| <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Sprains/Strains |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> TMJ problems | <input type="checkbox"/> Open Sores |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Tennis Elbow | |

Comments: _____

Please indicate with a circle, any areas you are feeling discomfort ~



Notes: _____

Informed Consent to Treatment

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain and/or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and nothing said in the course of the session given should be construed as such. Because massage/bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client signature: _____ Date: _____

***Consent to treatment of a minor ***

Signature of parent or guardian: _____ Date: _____