Healing Arts Therapeutic Massage

CLIENT INTAKE FORM

1649 S. Enterprise Ave. – Springfield, Missouri 65804

Phone: 417-886-4826

NAME: ______________________________ Date of Birth: ______________________

Street Address: ______________________ City: ______________ State: ____ Zip: __________

Telephone Number(s) HOME: ______________ WORK: ______________ CELL: ______________

Email Address: ______________________________

Emergency contact: ______________________________ Telephone: ______________________

Referred by: ____

GENERAL & MEDICAL INFORMATION

☐Male ☐Female Age: ________ I am: ☐Right Handed ☐Left Handed

Occupation: ______________________________ Employer: ______________________

Does your place of employment currently offer On-Site Chair Massage for staff members? ☐ YES ☐ NO

If NO, who may we contact at your place of employment to offer this stress relief service? ______________________

Physician: ______________________ Health Insurance Carrier: ______________________

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

If you answer YES to any of the following questions, please explain as clearly as possible.

Have you ever experienced a PROFESSIONAL MASSAGE or bodywork session? .... ☐ YES ..... ☐ NO

If YES, how recently & where? ______________________________

Do you frequently suffer from STRESS? .... ☐ YES ..... ☐ NO

Do you have DIABETES? .... ☐ YES ..... ☐ NO

Do you experience frequent HEADACHES? .... ☐ YES ..... ☐ NO

Are you PREGNANT? .... ☐ YES ..... ☐ NO

If YES, when is your baby due? ______________________________

Do you suffer from ARTHRITIS? .... ☐ YES ..... ☐ NO

Are you wearing CONTACT LENSES? .... ☐ YES ..... ☐ NO

Are you wearing DENTURES? .... ☐ YES ..... ☐ NO

Do you have HIGH BLOOD PRESSURE? .... ☐ YES ..... ☐ NO

If YES, are you taking medication for this? ______________________________

Do you suffer from EPILEPSY or SEIZURES? .... ☐ YES ..... ☐ NO

Do you suffer from JOINT SWELLING? .... ☐ YES ..... ☐ NO

Do you have VARICOSE VEINS? .... ☐ YES ..... ☐ NO

Do you have any CONTAGIOUS DISEASE? .... ☐ YES ..... ☐ NO

Do you have OSTEOPOROSIS? .... ☐ YES ..... ☐ NO

Do you have any RESPIRATORY CONDITIONS, such as Sleep Apnea? .... ☐ YES ..... ☐ NO

Do you have any ALLERGIES? .... ☐ YES ..... ☐ NO

Do you BRUISE easily? .... ☐ YES ..... ☐ NO

Have you had any BROKEN BONES in the past two years? .... ☐ YES ..... ☐ NO

Have you been in an ACCIDENT or suffered any INJURIES in the past two years? ..... ☐ YES ..... ☐ NO

(Continued on Back Side)

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Do you have TENSION or SORENESS in a specific area? .... ☐ YES ..... ☐ NO

Please specify *& mark on diagram below*: ____________________

Do you have CARDIAC or CIRCULATORY PROBLEMS? .... ☐ YES ..... ☐ NO

Do you suffer from BACK PAIN? .... ☐ YES ..... ☐ NO

Do you have NUMBNESS or STABBING PAINS anywhere? .... ☐ YES ..... ☐ NO

Are you very SENSITIVE TO TOUCH or PRESSURE in any area? .... ☐ YES ..... ☐ NO

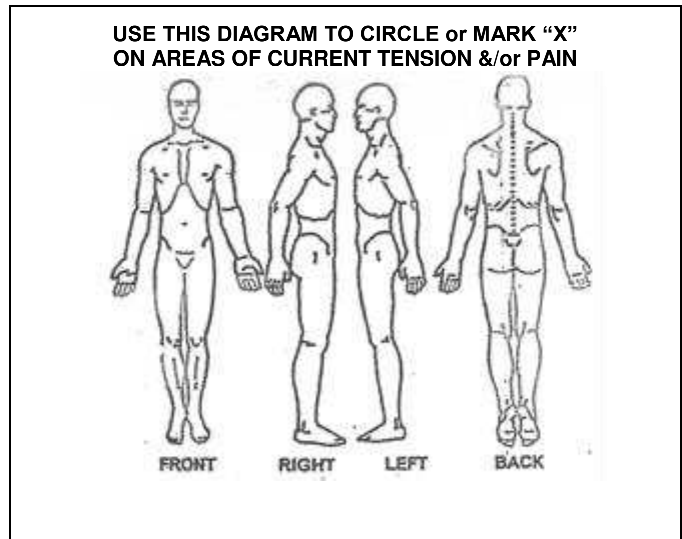
Have you ever had SURGERY? .... ☐ YES ..... ☐ NO

If YES, please explain: ____________________

Do you have any other medical condition, or are you taking MEDICATIONS? .... ☐ YES ..... ☐ NO

COMMENTS: ____________________

USE THIS DIAGRAM TO CIRCLE or MARK "X" ON AREAS OF CURRENT TENSION &/or PAIN



PRIVACY POLICY: I understand that *Healing Arts Therapeutic Massage* provides every reasonable safeguard to protect the confidentiality of my health information in compliance with State & Federal laws. I acknowledge that a copy of the Salon Privacy Policy is posted and available for my review anytime.

ACKNOWLEDGEMENT:

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 or discomfort during this 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 that I am aware of. 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 that 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 understand that I am expected to pay the customary fee for any appointment cancelled with less than four (4)-hours advance notice. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature: ____________________ Date: ____________

Practitioner Signature: ____________________ Date: ____________

Consent to Treatment of MINOR: By my signature below, I hereby authorize the licensed practitioners of Healing Arts Therapeutic Massage to administer massage, bodywork or somatic therapy techniques to my child or dependent, as they deem necessary.

Signature of Parent or Guardian: ____________________ Date: ____________