JERA
Massage Therapy & Holistic Services

MASSAGE CLIENT INTAKE & CONSENT FORM

General Information

Name: _____ Gender: ( ) Male ( ) Female

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Daytime Phone: _____ Cell: _____

Email Address: _____

Occupation/Employer: _____ Referred By: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Date of Birth: _____

Medical Background

Describe any surgeries, hospitalizations, accidents, or injuries you've had:

Less than 5 years ago: _____

More than 5 years ago: _____

Do you have any chronic, ongoing pain that you deal with on a regular basis? _____

Please explain: _____

Are you receiving any other type of medical treatment? _____ Please explain: _____

_____

Please list any medications (vitamins, herbs, or pharmaceutical) taken now or at regular intervals (including what medication is used to treat): _____

_____

Are you currently under the care of a physician? _____ Please list reason(s): _____

Are there any other health concerns you wish to discuss today? _____ If yes, please describe: _____

Massage Information

Is this your first professional massage? _____ If no, how frequently do you receive a massage? _____

Desired Pressure: Light _____ Firm _____ Deep _____

Please check any areas of your body that you would rather **BE AVOIDED/NOT MASSAGED** during the session:

❑ Back ❑ Feet ❑ Legs ❑ Buttocks ❑ Hands ❑ Arms ❑ Abdomen ❑ Pecs/upper chest ❑ Neck ❑ Head ❑ Face

I understand (1) that a combination of Swedish, deep tissue, trigger point, myofascial release and aromatherapy techniques may be used during the session, (2) that the therapist will not engage in breast massage of female clients without the client's written consent, (3) that draping will be used during the session, (4) that clients under the age of 17 must have written consent from a parent/guardian, and (5) that if the client is uncomfortable for any reason, he/she may ask for the massage to it end and it will.

Client signature: _____ Date: _____

Therapist signature: _____ Date: _____

Check the following conditions that apply, both past and present. Please add comments to clarify the condition.

MusculoSkeletal
- ❑ Headaches
- ❑ Joint stiffness/swelling
- ❑ Spasms/cramps
- ❑ Broken/fractured bones
- ❑ Strains/sprains
- ❑ Problems walking
- ❑ Jaw pain/TMJ
- ❑ Tendinitis
- ❑ Bursitis

Bone or joint disease
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Scoliosis
- ❑ Other: _____

Circulatory and Respiratory
- ❑ Dizziness
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Cold feet or hands
- ❑ Cold sweats
- ❑ Swollen ankles
- ❑ Varicose veins
- ❑ Blood clots
- ❑ Stroke
- ❑ Heart condition
- ❑ Allergies
- ❑ Sinus problems
- ❑ Asthma
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Lymphedema
- ❑ Other: _____

Skin
- ❑ Rashes
- ❑ Athlete's Foot
- ❑ Warts
- ❑ Moles
- ❑ Acne
- ❑ Cosmetic surgery
- ❑ Other: _____

Digestive
- ❑ Nervous stomach
- ❑ Indigestion
- ❑ Constipation
- ❑ Intestinal gas/bloating
- ❑ Diarrhea
- ❑ Diverticulitis
- ❑ Irritable bowel syndrome
- ❑ Crohn's Disease
- ❑ Colitis
- ❑ Adaptive aids
- ❑ Other: _____

Nervous System
- ❑ Numbness/tingling
- ❑ Twitching of face
- ❑ Fatigue
- ❑ Chronic pain
- ❑ Sleep disorders
- ❑ Ulcers
- ❑ Paralysis
- ❑ Herpes/shingles
- ❑ Cerebral Palsy
- ❑ Epilepsy
- ❑ Chronic Fatigue Syndrome
- ❑ Multiple Sclerosis
- ❑ Muscular Dystrophy
- ❑ Parkinson's disease
- ❑ Spinal cord injury
- ❑ Other: _____

Reproductive System
- ❑ Pregnancy:
  - ❑ Currently
    how far along? _____
  - ❑ Possibly
- ❑ Menopause
- ❑ Pelvic Inflammatory Disease
- ❑ Endometriosis
- ❑ Hysterectomy
- ❑ Prostate problems

Other
- ❑ Loss of appetite
- ❑ Forgetfulness
- ❑ Depression
- ❑ Drug use
- ❑ Alcohol use
- ❑ Nicotine use
- ❑ Hearing impaired
- ❑ Visually impaired
- ❑ Urinary tract infection
- ❑ Eating disorder
- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Cancer
- ❑ Infectious disease (please list)

_____

❑ Other congenital/acquired disabilities (please list)

_____

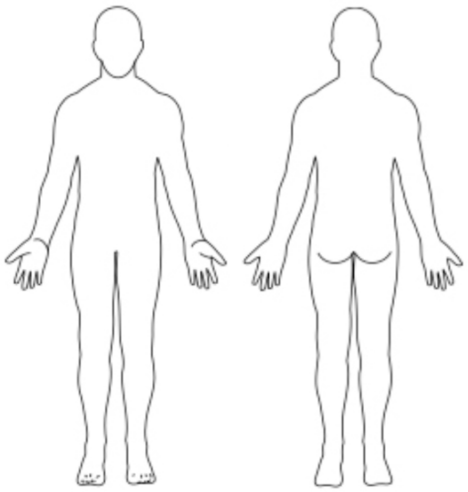
❑ Allergies
(please list)

_____

_____

❑ Surgeries _____
❑ Other: _____

Please indicate where you experience pain on the diagram below.



I understand that the massage 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 therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 therapists 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 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. 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: _____

Therapist signature: _____ Date: _____