**** Massage Therapy Wellness

Client Intake Form

**Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_

**Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **St**\_\_\_\_\_ **Zip**\_\_\_\_\_\_\_

**Email**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Job Description**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Daily Activities**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*How did you hear about us? Were you referred to us?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To help ensure safe and comfortable massage experience, please provide as much information to your healthcare practitioner/massage therapist as possible. All information in this Intake form is considered confidential and all HIPPA rules and regulations are followed at all times. Your therapist will take time to review to see if there are any changes on any/all subsequent visits.

**Health History**

*Allergies Anxiety/Depression Arthritis Asthma Blood Clots High/Low BP*

*Diabetes Vericosse Veins Scoliosis Vertigo Bruising Fibromyalgia*

*Migraines Disc Herniation Insomnia Thyroid Autoimmune Weight Gain*

*Edema Pain/Numbness Acute/Chronic Injuries Sciatica/Piriformis Syndrome*

***\*Recent surgeries (past 5 years)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***\*Medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***\*Are you currently under the supervision of another Healthcare practitioner such as a doctor, Physical Therapist, or Chiropractor? (If Yes: your therapy may be classified as Therapeutic until released from DR/PT/DC care.*** *YES NO*

***\*Professional Massages within the past year?*** *YES NO*

***\*Exercise:*** *DAILY WEEKLY NOT REALLY*

I understand that should any of the products used during these services create any reactions or discomfort or should the massage itself create any discomfort; I will notify my therapist at once. I understand that this work does not substitute medical treatment, but in some cases can be used in conjunction with medical treatment. Massage therapy is a form of holistic health, wellness and balancing maintenance. I take full responsibility for alerting my therapist of any physical or emotional conditions that could affect my massage treatment. By signing this form I do hereby waive and release My Happy Place LLC from all liability, past, present, and future.

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*If guest is under 18 years of age a Parent/Guardian must sign this release form in acknowledgment*

**Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**