# ISLAND PAIN RELIEF

# CLIENT INTAKE FORM

PLEASE PRINT LEGIBLY

Name _____ Email _____

Address _____ City:_____ State ___ Zip _____

Phone: Home_____Work_____Cell_____ Birth Month _____ Birth Year _____

Occupation _____ How did you hear about us? _____

In Case of Emergency Please Contact _____Phone_____

**General and Medical Information (Please circle Y for YES or N for No)**

Have you ever had a professional massage? Y / N If yes, how often? _____

Are you pregnant? Y / N If yes, how far along are you?_____

Are you sensitive to touch/pressure in any area? Y / N Ticklish? Y / N Are you allergic or sensitive to any oils (essential oils, nut oils, scents)? Y / N If yes, please list:_____

List of current medications and reason:_____

List of surgeries (type and date): _____

On a scale from 1-10, 10=highest, rate your levels of: Stress _____ Pain _____ Energy _____ How did your symptoms begin and when did they start? _____

What have you done for relief? _____

Is the condition getting better/worse? (circle one) Please check all that apply: □ Skin Problems □ Rash □ Warts □ Hives □ Skin cancer □ Lymphatic Problems □ Swollen Gland □ Nasal Congestion □ Lymph Edema □ Joint Problems □ Stiffness □ Arthritis □ Sacroiliac Problems □ TMJ □ Bone Condition □ Osteoporosis □ Fracture □ Headaches □ Recent injury: _____ □ Accident:_____ □ Whiplash □ Sprain □ Bruise □ Cut □ Scratch □ Any other type of injury at all_____□ Circulatory Problems □ High Blood Pressure □ Varicose Veins □ Blood Clots □ Numbness / Tingling □ Sciatica □ Tendonitis □ Bursitis □ Diabetes □ Other: _____ Describe your problem areas:_____ □ Hepatitis □ HIV/AIDS □ Cancer □ Seizures Any ailment, disease or problem not listed here:_____

Client's Signature_____ DATE:_____

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## Massage Therapy Client Waiver

## Client Intake Form Page 2 of 2

**Please take a moment to read all of the following statements and sign below:**

- If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
- I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.
- I affirm that I have notified my therapist of all known medical conditions and injuries and will inform her of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.
- I understand that massage is entirely therapeutic and non-sexual in nature. Any insinuation, joke, gesture, conversation, or request otherwise will result in immediate termination of your session and a refusal of any and all services in the future. You will be charged the full service fee regardless of the length of your session.
- I understand that should I cancel an appointment less than 24 hours before the scheduled time or "no show" an appointment, I am subject to a fee equal to the cost of the missed appointment.

By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

I have received the policy statement, and have read and agree to the policies therein.

Client Print Name:_____

Client signature:_____

Date:_____

Therapist signature:_____