The Heart of Healing
Massage Therapy and Energy Medicine

CLIENT INTAKE FORM

Name: _____ **Birthdate:** ____/____/____ **Today's Date** ____/____/____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

E-Mail _____ **Work Phone (_____)_____ (ext)____**

Home Phone: (_____)_____ **Cell Phone: (_____)_____** **Carrier*:** _____

Preferred Confirmation method: (we need carrier only if you wish to receive text messages)

◯ **E-Mail** ◯ **Home** ◯ **Cell (Voice and/or Text*)** ◯ **Check if you do not want to receive e-mails (for discount offers, newsletters, etc)**

****Please note we need at least one phone number so we can contact you if any changes to your appointment ****

How did you find out about us? ◯ **Internet Search** _____ ◯ **Promotional Site** _____

◯ **Facebook** ◯ **E-Mail** ◯ **Website** ◯ **Referral** **(please let us know who referred you so we can thank them)**

Referred By: Name: _____ **Relationship**_____

What is your occupation? _____

Emergency Contact Information:

Name _____ **Phone** _____ **Relationship** _____

Please check all that apply:

____ Heart Disease	____ Osteoporosis	____ Diabetes	____ High Blood Pressure
____ Cancer	____ Arthritis	____ Scoliosis	____ Pregnancy (stage) _____
____ Stroke	____ Heart Burn	____ Seizures	____ Fibromyalgia
____ Varicose veins	____ Skin condition	____ Sciatica	____ Other _____

Allergies? _____

Medications? _____

Have you ever had a Professional Massage before? ◯ **Yes** ◯ **No**

Any Areas we should Avoid? (Ticklish, Sensitive, Open Wounds, Rash, etc.) ◯ **Yes** ◯ **No**

Where? _____

Do you have any particular goals in mind for this massage session? ◯ **Yes** ◯ **No**

If yes, please explain _____

_____

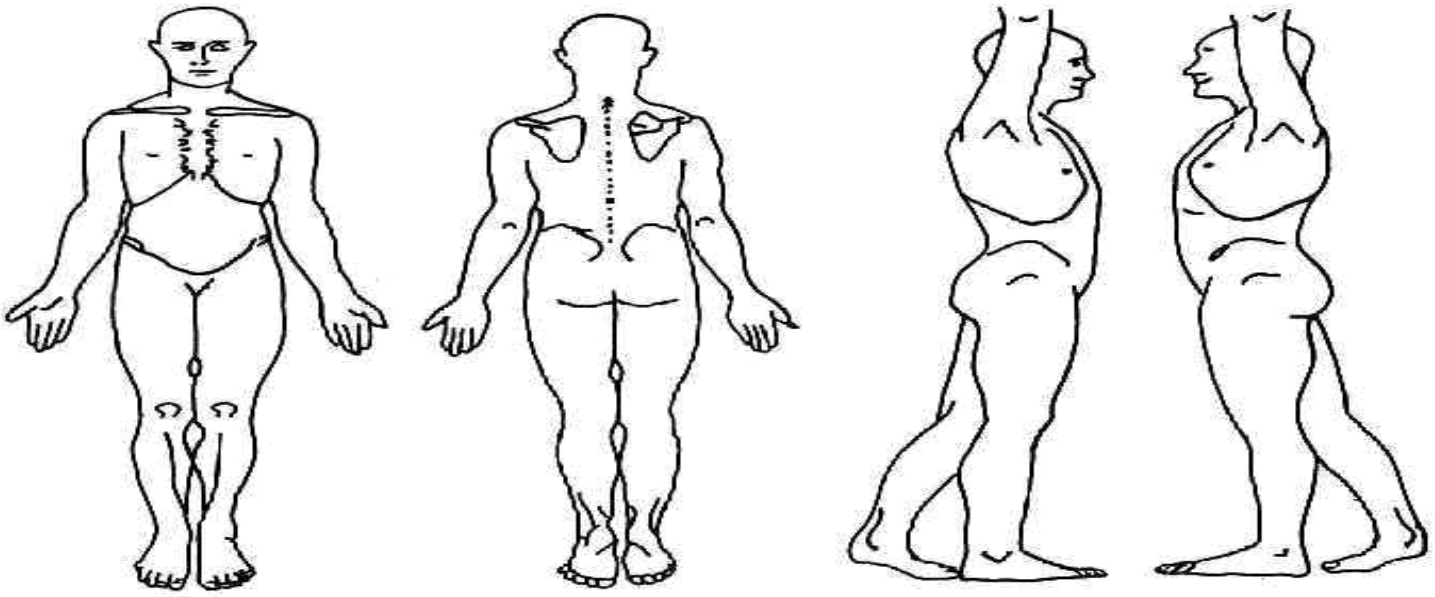
Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

_____

_____

_____

Please draw an X on any area that is painful and - - - - on any dull aches. Please rate your pain next to any X on a scale of 0-10 (0= no pain 10 = the worse pain you can imagine)



Please write anything else you think would be important for your therapist to know.

_____

_____

If you are ill or have a fever please let your therapist know so they can re-schedule since these are contraindications for massage and might lead to impaired heath.

Please feel free to ask your therapist any questions before, during, or after the massage.

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 this is therapeutic therapy and is completely non-sexual. Any illicit or sexually suggestive remarks or actions made by myself toward the therapist will result in an immediate end to the session and I will be liable for full payment of the scheduled session.

Please turn off your cell phone and enjoy your massage.

_____ _____

Signature of Client *Date*

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