



CLIENT INTAKE FORM

NC LMBT # 23497

Name: _____ Date: _____

Address: _____

Phone: _____ Date of Birth: _____

Referred to This Office By: _____

Emergency Contact: _____ Phone: _____

*Please answer the questions below*Have you ever had a professional massage? ☐ Yes ☐ No If yes, how often? _____Are you on any medication? ☐ Yes ☐ No If yes which ones? _____Are you sensitive to touch? (ticklish?) Yes ☐ No ☐*Please mark any of the conditions that you may have*

- | | | |
|---|---|--|
| ☐ Cancer | ☐ Alcohol within 24 hrs | ☐ Recent Surgery |
| ☐ Headaches / Migraines | ☐ Numbness | ☐ Open Wounds |
| ☐ Fibromyalgia | ☐ Recent Heart attack | ☐ Blood Clots |
| ☐ Arthritis | ☐ Bruises | ☐ Osteoporosis |
| ☐ Kidney Dysfunction | ☐ Rashes/Hives/Skin Condition | ☐ Neuropathy |
| ☐ Stroke | ☐ High Blood Pressure | ☐ Fever within 24 hrs |
| ☐ Diabetes | ☐ Varicose Veins | ☐ Pain Medication |
| ☐ Recent Cold / Flu | ☐ Acute Pain | ☐ Other please specify _____ |
| ☐ Sprain or Strain | ☐ Chronic Pain | |

Are you currently pregnant? ☐ Yes ☐ No Due Date: _____

Any high risk factors? _____

Do you have any allergies or sensitivities? ☐ Yes ☐ No If yes, please explain _____Are you allergic or sensitive to any oils? (Essential oils, nuts, scents) Yes ☐ No ☐

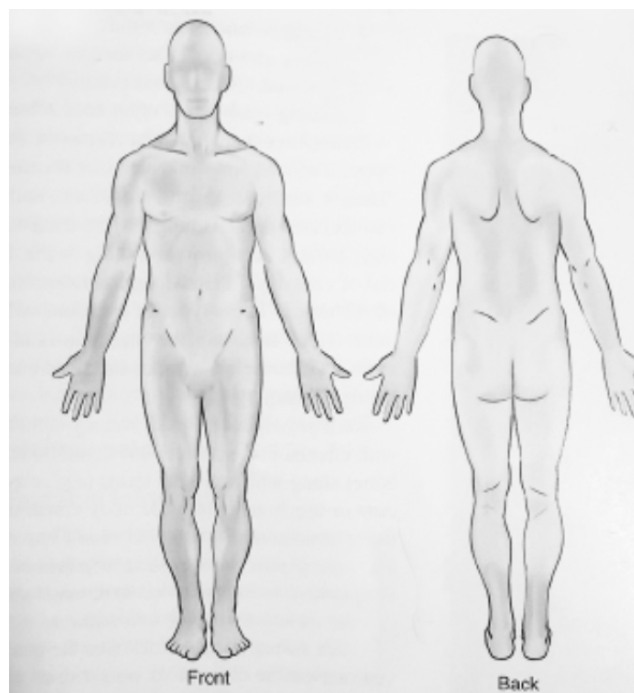
If yes please list: _____

What type of work do you do? _____ How many hours per day do you sit? _____

Do you exercise regularly? _____ If so how often? _____ What activity? _____

Stress level? 1-10 Scale _____

Please circle areas of discomfort



What areas would you like me to focus on?

What pressure do you prefer?

Light ☐

Medium ☐

Deep ☐

Are there areas you would NOT like massaged?

If so please list

(i.e., face, scalp, feet)

Please take a moment to check and initial next to the boxes and read the following statements

- ☐ I will have my phone on silent mode, including turning off vibration mode.
- ☐ If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure can be adjusted to my level of comfort.
- ☐ 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.
- ☐ I agree to inform the therapist of any changes in my health and medical condition.
- ☐ 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 understand that if I need to cancel an appointment, a 24 hours notice is required or
- ☐ I may be charged a \$50 fee.

SUGGESTIONS

- Prior to your massage, please remove all jewelry. Pull long hair back with a clip or band.
- In general, massage is given while you are unclothed. However, you may choose to wear undergarments or any other article of clothing you prefer.
- You will be covered with a top sheet throughout your session. This is your massage and you should be as comfortable as possible.

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

Client name: _____ Client Signature: _____

Date: _____ Therapist Signature: _____