HOPE/MCLEOD WELLNESS CENTERS

Massage Intake Form

*Name:*_____ *Home Phone:* _____

*Cell:*_____*Email:*_____

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

Date of Birth: _____ *Referred by:* _____

Occupation _____

Emergency contact name: _____ *Phone:*_____

Below are a few questions about your general lifestyle and health. We ask that you please take a few moments to carefully examine the information. With certain medical conditions or symptoms, receiving or performing massage may be contraindicated or require modifications. A referral from your primary care provider may be requested prior to receiving and/or performing massage.

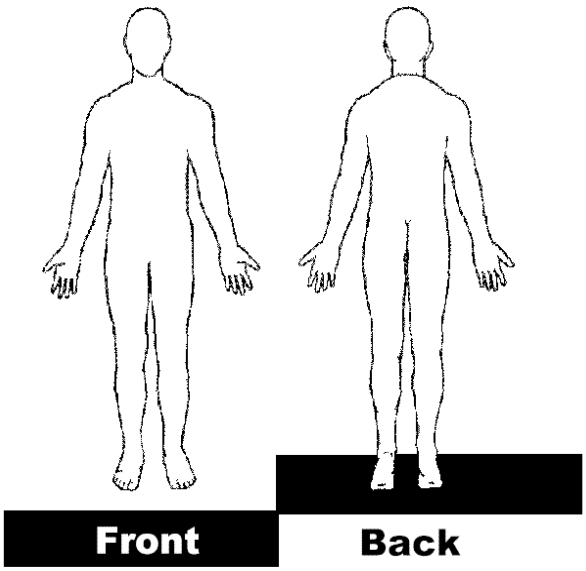
- *Have you received a professional massage before?* _____
- *Have you had any surgeries?* □*No* □*Yes; please list*_____

_____

- *Are there any areas of your body that you* **DO NOT** *want massaged?* _____

_____

- *Please indicate below the areas you would like your therapist to focus on;*



For Women Only:

- □ *Are you pregnant:* □*No* □*Yes, due date:* _____
- □ *Do you suffer from painful menstruation:* □*No* □*Yes*
- □ *Are you presently menstruating:* □*No* □*Yes*

Are you pre or menopausal: □*No* □*Yes*

Please continue to page 2

Please Mark All Current and Past Conditions

Integumentary System (Skin)

- ☐ *Warts*
- ☐ *Eczema*
- ☐ *Psoriasis*
- ☐ *Skin Cancer*
- ☐ *Skin Allergies*
- ☐ *Rashes*
- ☐ *Burns including Sunburn*
- ☐ *Bruise Easily*

*Other*_____

*Comments:*_____

Circulatory/Lymph/Endocrine System

- ☐ *High Blood Pressure*
- ☐ *Low Blood Pressure*
- ☐ *Varicose Veins*
- ☐ *Diabetes*
- ☐ *Clotting disorders*
- ☐ *Edema*
- ☐ *AIDS/HIV*
- ☐ *Lupus*
- ☐ *Cardiac Problems*

*Other*_____

*Comments:*_____

Current

- ☐ *Cold/ Flu/ Fever (if you are experiencing cold/flu/fever, session MUST be rescheduled for 48 hours after symptoms subside)*

*Other*_____

*Comments:*_____

Musculoskeletal System (Muscle)

- ☐ *Fibromyalgia*
- ☐ *Rheumatoid Arthritis*
- ☐ *Osteoarthritis*
- ☐ *TMJ dysfunction*
- ☐ *Strains, sprains, tendonitis*
- ☐ *Bursitis*
- ☐ *Carpal Tunnel syndrome*
- ☐ *Cramping, spasms, soreness*
- ☐ *Loss of motion or mobility*
- ☐ *Back Pain (circle which) Low Mid Neck*

*Other*_____

*Comments:*_____

Nervous System

- ☐ *Spinal cord injury*
- ☐ *Brain injury*
- ☐ *Numbness/tingling*
- ☐ *Headaches*
- ☐ *Stroke*
- ☐ *Seizure disorder*
- ☐ *Reduced sensation*
- ☐ *Dizziness*
- ☐ *Ringing in ears*
- ☐ *Difficulty Sleeping*

*Other*_____

*Comments:*_____

Cancer

*If you are a cancer patient, please explain type and treatment:*_____

_____

_____

By signing this form, I understand that the relaxation therapy/treatment I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner/therapist so that the pressure and/or strokes may be adjusted to my level of comfort or ceased entirely. I further understand that relaxation therapy/treatments should not be construed as a substitute for a medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailments that I am aware of. I understand that the practitioner/therapist is not a qualified doctor, and cannot perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness. Regardless of what the disease is called, the practitioner/therapist does not offer to heal or offer advice regarding the treatment of disease. I affirm that I have stated all known medical history, and understand that there will be no liability on Hope/McLeod Wellness Centers or the practitioner/therapist's part should I fail to update the practitioner as to any changes in the future or forget to do so in detail. I also affirm that I have not consumed any alcoholic beverages within 2 hours of my therapy/treatment, and I am not intoxicated. I understand that if I have consumed alcoholic beverages the benefits of the therapy/treatment may be contradicted. **I understand that any illicit or sexual suggestive remarks or advances made will result in immediate termination of the therapy/treatment session, and I will be liable for the immediate full payment of the scheduled appointment.** *If an appointment is cancelled in less than 24 hour notice, a fee of $25.00 will be applied.*

Signed, _____ _____

Client, Parent, or Guardian *Today's Date*

*Print Name:*_____