One Life Wellness Studio
Therapeutic Massage
Client Intake Form

Personal Information:

Name ____ Date____________________________________

Primary Phone _________________________ Email____

Address____

Ciity/State/Zip____

Date of Birth ___________________ Occupation____

Emergency Contact_____________________________________ Phone _____________________________

The following information will be used to help plan safe and effective massage sessions.

1. Have you ever had a professional massage before? Yes No
   If yes, how often do you receive massage therapy? ____

2. Do you have any difficulty lying on your front, back, or side? Yes No
   If yes, please explain ____

3. Do you have any allergies to oils, lotions, or ointments? Yes No
   If yes, please explain ____

4. Do you have sensitive skin or a skin condition? Yes No
   If yes, please explain ____

5. Are you wearing? ( ) contact lenses ( ) dentures ( ) hearing aid

6. Do you sit for long hours at a workstation, computer or driving? Yes No

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
   If yes, please explain ____

8. Do you experience stress in your work, family, or other aspects of your life? Yes No
   If yes, how do you think it has affected your health? ( ) muscle tension ( ) anxiety ( ) insomnia ( ) irritability
   other ____

9. Do you have any particular goals in mind for this massage session? Yes No
   If yes, please explain ____

10. Do you see a chiropractor? Yes No If yes, how often? ___________________________________

11. Are you currently under medical supervision? Yes No
    If yes, please explain____

12. Are you currently talking any medication? Yes No
    If yes, please list____

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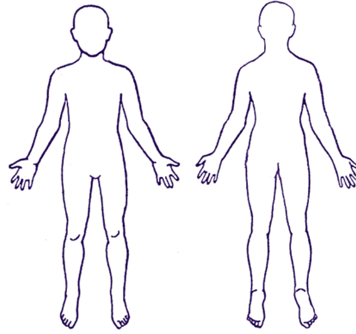
13. Please circle any areas that are currently bothering you or are common problem areas that require extra attention



14. Please circle any condition listed below that applies to you:

( ) Recent surgery	( ) Fracture/injury	( ) Epilepsy
( ) Artificial joint	( ) Sprains/strains/tendonitis/carpal tunnel	( ) Fever/swollen glands
( ) Varicose veins	( ) Phlebitis/deep vein thrombosis/blood clots	( ) Joint disorder
( ) Cancer	( ) Numbness/neuropathy	( ) Fibromyalgia
( ) Epilepsy	( ) Pregnant or possibly pregnant	( ) Unstable blood pressure

Please explain and state duration of any condition that you have marked: ________________________

____

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

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Draping will be used during the session to respect the client's privacy. Clients under the age of 17 must have the approval of a parent or legal guardian.

Acknowledgement of Risk and Waiver of Liability

I, _______________________________________ (print name) 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 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 as 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.

Cancellation and Payment Agreement

Missed sessions will be charged. If an appointment is cancelled with less than 24 hours notice, (with the exception of illness or emergency situations where a 1 hour notification will be accepted) OR if you do not attend a scheduled appointment, the session fee will be charged to the credit card on file OR deducted from your prepaid package.

Signature of client ____ Date______________________

Signature of Massage Therapist___________________________________ Date______________________