Massage Intake Form

Client Information

Name____

Phone _________________________________ DOB________________________________

Address____

City__________________________ State________________ Zip___________________________

Email____

Sex assigned at birth_______________________ Gender identity__________________________________

Preferred Pronouns **she/her** **he/him** **they/them** Physician________________________________

Are you interested in Nutritional Counseling in order to reach your wellness goals? **Yes** **No**

Emergency Contact: _______________________________________ Phone__________________________

Referred by ____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever had a professional massage or bodywork session? **Yes** **No** When? ________________

What are your massage or bodywork goals? ____

____

What kind of pressure do you prefer? **Light** **Medium** **Deep**

If you answer "yes" to any of the following questions, please explain as clearly as possible.

Yes **No** Do you frequently suffer from stress?
Yes **No** Do you have diabetes?
Yes **No** Do you experience frequent headaches?
Yes **No** Are you pregnant?
Yes **No** Do you suffer from arthritis?
Yes **No** Are you wearing contact lenses?
Yes **No** Are you wearing dentures?
Yes **No** Do you have high blood pressure?
Yes **No** Are you taking blood pressure meds?
Yes **No** Do you suffer from epilepsy or seizures?
Yes **No** Do you suffer from joint swelling?
Yes **No** Do you have varicose veins?
Yes **No** Do you have any contagious diseases?
Yes **No** Do you have osteoporosis?

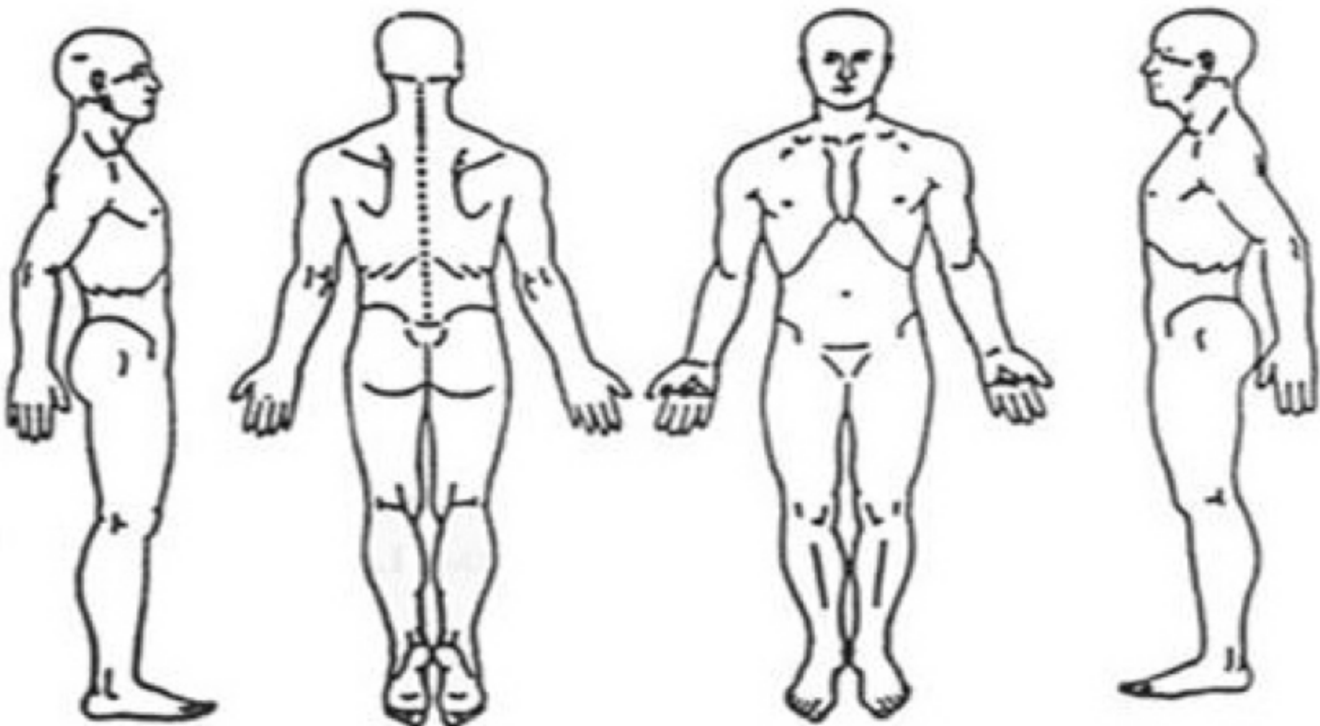
Yes **No** Do you have any allergies?
Yes **No** Do you bruise easily?
Yes **No** Any broken bones in the past?
Yes **No** Any injuries or car accidents?
Yes **No** Do you have soreness/tension in a specific area____________________
Yes **No** Do you have cardiac/circulatory problems?
Yes **No** Do you suffer from back pain?
Yes **No** Do you have numbness or stabbing pain? Where?____________________
Yes **No** Have you ever had surgery? Explain below
Yes **No** Any other medical conditions, or medications I should know about

____

____

____

Please mark areas with the appropriate symbol as it relates to your symptoms
P – Pain **T – Tension** **N –numbness/tingling** **B – Burning** **S – Stabbing**



Cancellation Policy Acknowledgement
I understand that *Pernell Wellness* has a 24-hour cancellation policy, and that **I may cancel my appointment without charge one full business day prior to my appointment.** Cancellations with less than a full business day's notice will be charged 50% of the scheduled service price. If you do not cancel your appointment or do not show up for your scheduled appointment, you will be charged full price for the scheduled service. ***Initial*** ____________

Client Agreement
I understand that the massage/bodywork 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 practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork 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 of which I am aware. I understand that massage/bodywork practitioners 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/ bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature _____________________________________ Date____________________________