

Client Information

Name _____ Date of Birth _____

Address _____ City _____ State ____ Zip _____

Day Phone _____ Evening Phone _____ Occupation _____

Emergency Contact Name _____ Emergency Phone _____

Would you like to be on our mailing list? ___ yes ___ no If yes, email address _____

Have you ever had a professional massage? ___ yes ___ no

How did you hear about us? _____

Many conditions can affect our massage treatment plan. Please check conditions you have or have had in the past:

Current	Past		Current	Past		Current
_____	_____	bone/joint disease	_____	_____	sinus problems	_____
_____	_____	neck/shoulder/arm pain	_____	_____	stroke	_____
_____	_____	low/mid back pain	_____	_____	broken/fractured bones	_____
_____	_____	hip/leg pain	_____	_____	diabetes	_____
_____	_____	TMJ dysfunction/jaw pain	_____	_____	high blood pressure	_____
_____	_____	whiplash	_____	_____	low blood pressure	_____
_____	_____	tendonitis/bursitis	_____	_____	sleep disorders	_____
_____	_____	headaches/head injuries	_____	_____	breathing difficulty	_____
_____	_____	numbness/tingling	_____	_____	varicose veins	_____
_____	_____	auto-immune disorder	_____	_____	epilepsy	_____
_____	_____	lymphedema	_____	_____	heart condition	_____
_____	_____	blood clots	_____	_____	nicotine addiction	_____
_____	_____	sciatica	_____	_____	caffeine addiction	_____
_____	_____	fibromyalgia	_____	_____	alcohol/drug addiction	_____
_____	_____	chronic pain	_____	_____	eating disorders	_____
_____	_____	herpes/shingles	_____	_____	skin condition:	_____
_____	_____	depression	_____	_____	cancer (type _____)	_____
_____	_____	constipation	_____	_____	vertigo/dizziness	_____
_____	_____	irritable bowel syndrome	_____	_____	other: _____	_____
_____	_____	limited range of motion	_____	_____	_____	_____

Are you pregnant? ___ yes ___ no # of months _____

~ If so, do you have doctor's permission? ___ yes ___ no

Are you currently taking any medications? ___ yes ___ no If yes, please list:

Do you currently have any pain or discomfort? ___ yes ___ no If yes, where?

Do you have any infectious diseases? ___ yes ___ no If yes, please list:

Do you have any allergies? ___ yes ___ no If yes, please list:

Have you had any surgeries? ___ yes ___ no If yes, please list:

Have you ever been in a car/other serious accident? ___ yes ___ no If yes, please list:

Have you taken any pain medication today? ___ yes ___ no If yes, please list:

Please read and sign below:

I have stated all known medical conditions on this form and answered all questions honestly. I understand that massage/bodywork may be contraindicated for certain conditions. I will update the massage therapist of changes in my medical profile, and understand there will be no liability to the massage therapist should I fail to do so. A referral from my primary care physician may be required prior to services being provided. If I experience any pain or discomfort, I will immediately notify the massage therapist. Massage/bodywork should not be construed as a substitute for medical examination, diagnosis or treatment. I understand that the massage therapist is 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(s) shall be construed as such. Any illicit or sexually suggestive remarks or advances will result in immediate termination of the session, and I will be liable for payment of the appointment. I understand that my records are protected under confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided in the regulations. I may revoke this consent at anytime except to the extent that action has been taken in reliance on it, and that, in any event, this consent expires upon my notification. I acknowledge that the information to be released was explained to me and consent is given of my own free will.

Signature _____ Date _____

Cancellation Policy We appreciate your promptness, professional consideration and courtesy.

I understand that Harbor Health and Massage LLC(HHM) requires a 24 hour notice to cancel my appointment without penalty. Should I miss an appointment without giving this notice, HHM has the right to bill me for the appointment. If I have a prepaid package, the cost will be deducted automatically. However, if I send someone to take my place, I will not be responsible for payment of the session unless s/he does not show. By signing below, I acknowledge that I have read and understand the cancellation policy.

Signature _____ Date _____

*******For Therapist Use Only*******

Client Intake Form... Revised 12/2013

Session Date: _____ Time: _____ Duration _____ Hour _____ Minutes

Practitioner: _____

SUBJECTIVE: (Current History, Complaint, Goals for Today's Session)

OBJECTIVE: (Techniques used, Muscles Targeted, Therapeutic Assessment, Self-Care Demo)

Swedish Massage Myofascial Release NMT Craniosacral Therapy

Other _____

Full Body Upper Body Lower Body Scalp/Face

Other _____

Muscle(s)/ Areas Targeted: _____

Stretches and Self-

Care: _____

ASSESSMENT: (Results of Session, Client Response)

PLAN: (Homework, Referrals, Plan or Suggestion for Next Visit) _____
