Massage Intake Form

Achievable Health 515-201-2256 achievablehealthcoach@gmail.com

Name _____ Phone Number(s) _____

Address _____

City/State/Zip _____

Email _____ Date of Birth _____ Occupation _____

Emergency Contact _____ Phone Number _____

The following information will be used to help facilitate an optimal personalized massage session. Please answer the questions to the best of your knowledge.

Today's date _____ Is this your first professional massage? Yes No

If no, when was your last massage and how often do you receive them? _____

_____

Do you have sensitive skin? Yes No

Are you wearing contact lenses ( ) dentures ( ) hearing aids ( )?

Do you have difficulty lying face down, on your back or on your side? Yes No

If yes, please explain _____

Are you allergic to any essential oils, lotions or ointments? Yes No

If yes, please list them _____

At this moment, where are the particular areas in your body that you are experiencing pain, stiffness, tension or other discomfort? _____

_____

_____

Do your daily activities or exercise activities agitate your symptoms? Yes No

If yes, please list them and explain length of the activity _____

_____

_____

Do you experience stress from your work, family or other aspects of life? Yes No

If yes, how do you think it affects your health?

muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other _____

What are your goals for this massage session? Example: I would like to get relief from my stiff neck. _____

_____

_____

_____

Medical History

To enable this massage session be optimal for your specific health needs, some general information regarding your medical history is needed.

Are you currently under medical supervision? Yes No

If yes, please explain _____

_____

Do you regularly see a chiropractor? Yes No

Are you currently taking any medications and/or supplements? Yes No

If yes, please list _____

_____

Please check any conditions listed below that apply to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or serious injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis
( ) phlebitis
( ) deep vein thrombosis/ blood clots
( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) Fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) pregnancy If yes, how many months? _____

Please elaborate any conditions that were marked above _____

_____

_____

Is there anything else regarding your health history that you think would be helpful for your massage therapist to know to facilitate the most beneficial massage session for you? _____

_____

It is crucial that communication be a key factor to this massage session. Please inform the therapist immediately if the pressure is too much or too little or if you feel uncomfortable at any time.

I hereby acknowledge that massage therapy is provided for the purposes of stress reduction, relief from muscular tension, relaxation and improvement of circulation. I understand my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, treat, prescribe medications for any physical or mental illness. I further acknowledge the services provided today are not a substitute for medical care and massage therapy can cause some discomfort or pain subsequent to treatment. I acknowledge it is important to follow massage therapy services with proper hydration and stretching. In the event I experience any pain or discomfort at any time during the session, I will immediately inform my therapist of such so he/she can adjust the massage technique in accordance with my level of comfort. I hereby agree not to hold my therapist responsible for any pain or discomfort experienced during or after the session and acknowledge my therapist does not guarantee resolution or cure of any problem/ailment. I acknowledge is it my sole and absolute responsibility to inform the therapist of any changes in my health and medical condition, allergies or special needs. By signing this form, I hereby affirm I have informed my therapist of all known medical conditions and injuries, both past and present, and I forever release, acquit, discharge indemnify and hold harmless VFR, LLC, Achievable Health, its affiliates, owners, members, officers, directors, employees, volunteers, agents, contractors, representatives, attorneys, insurers, successors, assigns (individually “Released Party”; collectively “Released Parties”) from any and all actions, claims, demands, controversies or rights of whatever kind or nature that I, my assignees, heirs, distributees, guardians, next of kin, spouse, insurers and/or legal representatives now have, or may have in the future, whether now known or anticipated, or which may later develop or be discovered, including all effects and consequences thereof, related to the performance of massage therapy services. I fully intend for this Release and Waiver of Liability to be binding on my assignees, heirs, distributees, guardians, next of kin, spouse, insurers and legal representatives.

If client is under 18 years of age, a parent or legal guardian must sign waiver.

Client _____ Date _____

Massage Therapist _____ Date _____