Client Intake Form

Serenity Massage - Barbara Adams, LMT

All information will be held in the strictest confidence and will not be shared without your consent.

Name _____ Phone: cell (_____)_____ home (_____)_____

Address _____ City _____ State _____ Zip _____

DOB _____ Email: _____ Referred by: _____

Occupation: _____ ☐ Male ☐ Female Physician: _____

In case of emergency: _____ Phone (_____)_____

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 not be appropriate. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? ☐ yes ☐ no How recently? _____

What are your massage or bodywork goals? _____

Please rate the importance of each of these goals for today's session (1 = not very important; 5 = the most important)
Relaxation: 1 2 3 4 5 Pain Relief: 1 2 3 4 5 Increased Flexibility/Movement: 1 2 3 4 5

What kind of pressure do you prefer? ☐ light ☐ medium ☐ firm

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

☐ yes ☐ no Do you suffer from stress? (moderate or severe?)
☐ 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 Have you ever had a stroke?
☐ yes ☐ no Have you ever had a blood clot, or DVT?
☐ yes ☐ no Do you have high blood pressure?
☐ yes ☐ no Are you taking blood pressure medication?
☐ 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 two years?
☐ yes ☐ no Any injuries in the past two years?
☐ yes ☐ no Do you have tension or soreness in a specific area?
Please specify _____
_____
☐ yes ☐ no Do you have cardiac or circulatory problems?
☐ yes ☐ no Do you suffer from back pain?
☐ yes ☐ no Do you have numbness or stabbing pains?
☐ yes ☐ no Are you sensitive to touch or pressure in any area?
☐ yes ☐ no Have you ever had surgery? Explain below.
☐ yes ☐ no Any other medical conditions or medications I should know about?
Comments: _____
_____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension and associated conditions. The practitioner may use integrated bodywork and stretching techniques, and draping will be used at all times unless agreed to by both parties. If I experience any pain or am uncomfortable during this session for any reason, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort or I may choose to end the session. 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. Genital areas (and breasts for females) will not be massaged, and 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 _____

Practitioner Signature _____ Date _____

Consent to treatment of a minor: By my signature below, I hereby authorize Barbara Adams, LMT to administer massage, bodywork, or somatic therapy techniques to my child or dependent as she deems necessary.

Signature of parent or guardian: _____ Date _____