Massage Intake Form

Massage will not be performed if you arrive intoxicated, under the influence of drugs, needing to bathe or unreasonably late. In accordance with state laws, your body will be properly draped (covered) at all times, except for the area being worked.

Contact Information

Name ____ Nickname: ___________________ Birthdate ___________________

Address ______________________________________ City ______________________ State ______ Zip Code ___________

Occupation ______________________________ Day phone __________________ Evening phone ___________________

E-mail: ____Have you ever had a professional massage? Yes ____ No ____

What do you hope to gain from massage therapy? ____

Current Medical Information

Are you currently under medical care? Yes ___ No ___ If yes, please explain _______________________________________

Are you receiving professional counseling? Yes ____ No ___ If yes, please explain ___________________________________

Is there **ANY** chance you are pregnant or trying to conceive? Yes ___ No ___ If pregnant, number of weeks __________

Please list all medications/vitamins/herbal supplements you are currently taking ______________________________________

____

Do you wear contacts? Yes_____ No_____ Dentures? Yes_____ No_____ Hearing aid? Yes_____ No_____

Medical History

All of this information is confidential, and cannot be shared with anyone by law. Please include any recent rashes, bruises, bumps, breaks, sprains, strains, fractures, illnesses, or surgeries. A partial list follows but is not meant to be all-inclusive.

___ Abscess/open sore/surgical site
___ Allergies
___ Arteriosclerosis
___ Asthma
___ Cancer/undiagnosed lump
Type ___________________
Diagnosed date ___________
Last treatment ___________
___ Chronic fatigue syndrome
___ Depression
___ Diabetes
___ Digestive problems
___ Easy bruising
___ Epilepsy
___ Fluid retention
___ Fractures/breaks/sprains

___ Fibromyalgia
___ Fibrositis
___ Headaches
___ Heart disease
___ Herniated/ruptured disc
___ Hepatitis
___ Herpes I or II
___ History of mental illness, Physical or emotional abuse, Counseling/therapy
___ HIV/AIDS
Diagnosed date ___________
Last treatment ____________
___ Hypertension
___ Inner ear problems
___ Insomnia

___ Implants
Where _________________
___ Lupus
___ PMS/troublesome cycle
___ Pregnancy (currently)
___ Osteoarthritis
___ Osteoporosis
___ Phlebitis
___ Rheumatoid Arthritis
___ Skin sensitivity
___ Stomach ulcers
___ Varicose veins
___ Other conditions *(include past injuries)* that still affect you:
____
____

Physician Information

(This section MUST be completed if you have conditions such as Diabetes, High Blood Pressure, Lupus, Cancer, HIV/AIDS, etc.)

Physician's Name ___________________ Phone ___________________ City ________________ State _____ Zip ______

Do we have your permission to contact your healthcare provider if needed? Yes _______ No _______

Lifestyle/Fitness Routine

How often do you exercise weekly? _____________ What type(s)? ____

Do you use tobacco? Yes _____ No _____ Alcohol? Yes _____ No _____ Caffeine? Yes _____ No _____

How many glasses of water do you consume daily? ______ On a scale of 1 to 10, what is your stress level? _____

What type of massage pressure do you prefer? Featherlight ____, Gentle ____, Moderate ____, or Deep/Heavy ____

Is there any area of the body where you seem to hold a lot of tension? _______________________________________

I have read the preceding information and understand it is my responsibility to inform the therapist of any of my health challenges and issues **prior to EACH** session. I understand that any medical condition/illness/injury that I currently have MUST be documented on this form, and the therapist cannot be held liable for any adverse reactions related to any conditions that have been concealed by me. I understand that this work does not constitute medical treatment. It is a form of health maintenance and wellness, utilizing the techniques of traditional massage.

Client Signature ____ **Date** _________________

Referred by ____

May I contact you by Phone__ Text___ or E-mail____ to confirm your appointments?
Check box that applies

Massages By Misty

STATE OF BEING

Be prompt. Sessions begin and end at scheduled times.

Be clean when you arrive for the treatment.

Be present (not under the influence of alcohol or drugs).

CONFIDENTIALITY

Client information is kept strictly confidential. Your therapist respects client confidentiality and will not share identifying client information with outside parties.

FOR YOUR COMFORT

Turn off cellular phones and beepers during the course of the massage session. Remove all jewelry.

NO SHOW POLICY

We ask that you please call 24 hours in advance if you are unable to keep your appointment. This gives the opportunity for another client to fill the appointment.

It is the policy of Massages By Misty to charge the client a fee of $30.00 if they have an appointment and do not call to cancel it and do not show up for the appointment. We allow 2 no-show appointments before beginning to request pre-payment for the treatment.

Upon the second no-show, a reminder letter is sent to you regarding the policy which again states that there are only 2 no-show appointments allowed before pre-payment is required and asks that you please call if you are unable to come in for your scheduled appointment.

CANCELLATION POLICY

Your appointment time is reserved for you alone. Please give 24 HOURS NOTICE if you will be unable to make your scheduled appointment to allow time to fill the vacant time slot. If you cancel or reschedule an appointment with less than 24 hours notice, or if you fail to show for an appointment, you may billed for the entire appointment. Emergency cancellations are determined at the therapist's discretion.
In the rare event the therapist must cancel your session, you will be notified as soon as possible. Last minute cancellations by the therapist will result in a FREE gift card given equal to the value of the treatment that was scheduled.

LATE POLICY

Please arrive on time as your appointment begins at the scheduled time. Because appointments are often booked next to each other, extra time may not be added to the end of your appointment and you will be charged for the full amount of time that was reserved for you.

PAYMENTS AND RETURNED CHECKS

Payment is due in full at the time service is rendered.

Cash, Check, MasterCard, Visa, Discover, and Debit cards are accepted.

There will be a $30.00 returned check fee - or maximum allowed by law.Gift Certificates are non-refundable. Keep in mind they are transferable; therefore, the bearer is considered the intended recipient regardless of the name printed on the certificate.

I have read and agreed to the policies stated above

______________________________ ________________

Signature Date