SOMA WISE
MASSAGE THERAPY

With Miriam Joy Dowd

CLIENT INTAKE INFORMATION FORM

Name: ______________________________ Date: ______________________

Address: ____________________ City: ___________ State: ______ Zip: ________

Phone(s): __________________________ Email: ________________________

Preferred method of contact: ______________ Height: ________ Weight: ___________

Occupation: _____________________ Employer: __________________________

Referred by: ____________________ Physician: _________________________

Emergency Contact (Name, Number, Relation): ________________________________

Previous experience with massage, if any: __________________________________

Primary reason for appointment/bodywork: ___________________________________

____

Please mark (X) for all Current conditions, and (P) for all Past conditions, and (F) for conditions relating to Family History.

___ headaches, migraines
___ vision problems, contact lenses
___ hearing problems, deafness
___ injuries to face or head
___ sinus problesm
___ dental bridges, braces
___ jaw pain, TMJ problems
___ asthma or lung conditions
___ constipation, diarrhea
___ hernia
___ birth control, IUD
___ abdominal or digestive issues

___ chronic pain
___ muscle or joint pain
___ muscle or bone injuries
___ numbness or tingling
___ sprains, strains
___ arthritis, tendonitis
___ cancer, tumors
___ spinal column disorders
___ diabetes
___ pregnancy
___ heart, circulatory problems
___ fatigue

___ tension, stress
___ depression
___ sleep difficulties
___ allergies, sensitivities
___ rashes, athletes foot
___ infectious diseases
___ blood clots
___ varicose veins
___ high/low blood pressure
___ other medical conditions not listed

Explain all marked conditions (write above or use lines below): ______________________

____

Previous and current injuries: ____

Please note history of surgeries: ____

Main physical activities for work, exercise, or free-time: ____________________________

____

Medications or supplements: ____

Do you have any allergies or aversions to any oil, lotion, therapeutic scents: ___________________

Any areas to avoid? (face, hair, abdomen, etc.): ________________________________

Are you right or left hand dominant? Right ____ Left ____

RELEASE OF LIABILITY

I understand that the massage session is provided for the basic purpose of relaxation, stress reduction and relief of muscular tension. I further understand that massage is not a substitute for medical examination, diagnosis or treatment for any mental or physical ailment or condition that I am aware of. I should see a physician, chiropractor or other qualified medical specialist. I also understand that the massage therapist does not diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such.

I affirm that I have stated all my known medical conditions, and answered all questions on this form and/or asked by the therapist, honestly and completely to the best of my knowledge. I am aware that massage is contraindicated (should not be performed) under certain medical conditions.

If I experience any pain or discomfort during this and any future sessions, I will immediately inform the therapist so the pressure/techniques may be adjusted to my comfort level.

__________ Initial Here

NO FRAGRANCE POLICY:

I will not wear synthetic fragrances including: perfumes/cologne, scented lotions, hair spray/products, deodorant/antiperspirant, fabric softener to any future sessions.

_________ Initial Here

CANCELLATION/TARDINESS POLICY:

I will give at least 24 hours notice for cancellation or rescheduling for any future appointments, or else I will be liable for the full fee of the session missed. I may proceed with a session I am tardy arriving to before 20 minutes into my allotted appointment.

_________ Initial Here

Client Signature: __________________________________ Date: ________________

Practitioner Signature: _____________________________ Date: ________________