

Driftless Massage Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____
 Address _____ City/State/Zip _____ DOB _____
 Occupation _____ Employer _____
 Email _____ Primary Physician _____
 Emergency Contact _____ Relationship _____ Phone _____
 How did you hear about us? _____

Medical Information

Are you taking any medications? yes no
 If yes, please list name and use: _____

 Are you currently pregnant? yes no
 If yes, how far along? _____
 Any high risk factors? _____
 Do you suffer from chronic pain? yes no
 If yes, please explain _____
 What makes it better? _____

 What makes it worse? _____

 Have you had any orthopedic injuries? yes no
 If yes, please list: _____

Please indicate any condition you have had in the past or currently have.

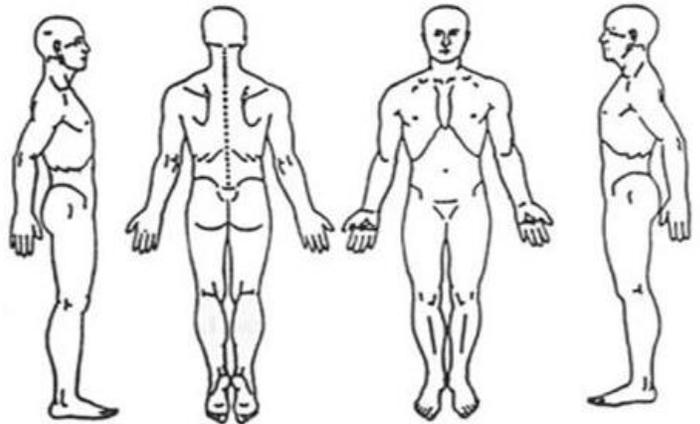
- | | |
|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Joint Replacement(s) | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Sprains or Strains |

Explain any conditions you have marked above:

Massage Information

Have you had a professional massage before? yes no
 What type of massage are you seeking?
 Relaxation Therapeutic/Deep Tissue
 Other _____
 What pressure do you prefer?
 Light Medium Deep
 Are you sensitive to any fragrances? yes no
 Are there any areas (feet, face, abdomen, etc.) you do not want massaged? yes no
 Please explain _____
 What are your goals for this treatment session?

Please circle any areas of discomfort



Draping will be used during the session - only the area being worked on will be uncovered. Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____ (print name) understand that the massage I receive is provided for the purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said during the session given should be construed as such. Because massage 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapists part should I fail to do so.

We understand that during a massage, a relaxing environment is desired and our office does our best at keeping noise to a minimum. However at times, normal office sounds (ie: a ringing phone) may be heard from the massage room.

No call, no show appointments, as well as cancellations within less than 12 hours of appointment time will be responsible for a \$25 late fee before being allowed to schedule another appointment.

I hereby attest that the information on this form is filled out to the best of my knowledge. I also understand and accept the cancellation policy.

Signature of client _____ Date _____