Bonnie Ross Massage LLC

Client Intake Form

Today's Date:_____

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

Occupation:_____

Primary Reason for Appointment:_____

1. Have you ever had a professional massage before? Yes No

2. Are you under the care of any medical practitioner? Yes No

3. Are you taking any medications? Yes No

If Yes, please list:_____

4. Before treatment: if you have any recent or chronic medical conditions, please check them below and discuss them with your massage therapist, it is pertinent to your massage experience:

Have you had or do you have any of the following:

_____Allergies to essences or oils

_____Anemia

_____Arthritis

_____Back or neck discomfort or injuries

_____Blood clotting disorders

_____Car accidents

_____Circulatory or heart problems

_____Diabetes

_____Digestive problems

_____Dislocations, sprains or strains

_____Epilepsy

_____Fainting spells or dizziness

_____Fractures or other bone trauma

_____Headaches

_____Herniated disks

_____High blood pressure

_____Jaw pain or injury

_____Nausea

_____Neurological problems

_____Malignant condition or cancer

_____Muscle cramping

_____Numbness, tingling

_____Recent surgery (explain on back of this form)

_____Respiratory problems

_____Skin conditions, irritations, lumps

_____TB or other communicable diseases

_____Ulcers

_____Varicose veins

Are you wearing contact lenses? Yes No

Are you wearing dentures? Yes No

Are you pregnant? Yes No

Have you had alcohol in the last hour? Yes No

5. Do you have any other medical conditions that your therapist should be aware of before giving you a massage? Yes No **If yes,** please explain: _____

_____

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Please initial:

_____ *I understand that the purpose of this massage is for stress reduction, relief from muscular tension or spasm, or for increasing circulation. I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals. This massage session is not a substitute for medical examinations and/or diagnosis. It is recommended that I see a physician for any physical ailments that I may have. I understand that the massage therapist needs to be aware of existing physical conditions; therefore, I have stated all of my known medical conditions and will take it upon myself to keep the massage therapist updated on my physical health.*

_____ *I also understand that any illicit or sexually suggestive behavior, remarks, or advances made by me will result in the immediate termination of the session and I will be liable for payment of the scheduled appointment.*

Signature: _____ Date:_____

If you are a minor (under 18 years of age), parent or guardian must sign below.

I am the legal guardian of client, and hereby consent him/her to receive massage services. I have read the above and hereby agree on behalf of myself and the client to its terms.

Signature:_____ Date:_____

Details of Recent Surgery (if needed):_____

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