Resilience Massage and Wellness

Client Intake Form

Name: _____ **D.O.B:** _____

Email: _____**Phone:**_____

Emergency Contact: (Name) (Telephone) _____

Occupation: _____**Sports/Hobbies/Daily Activities**_____

When was your last professional massage?_____**How did you hear about us?**_____

Circle any that apply: MILITARY VETERAN K-12 TEACHER FIRST-RESPONDER PHYSICIAN REFERAL

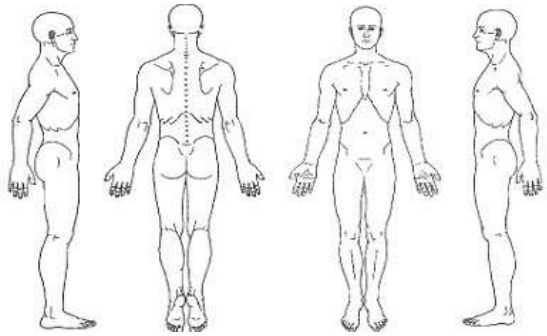
Desired Pressure: Light Medium Firm Deep Stretch

Do you have a goal in mind? _____

Are you sensitive to scents/oils? _____

Do you perform any repetitive movement in your work, sports, or hobby? _____

Is there a specific area of the body where you are experiencing tension, stiffness, pain or discomfort?



No Pain 1 2 3 4 5 6 7 8 9 10 Severe

Are there any areas that you do NOT want worked?

Face Scalp Pecs Abdomen Hands Glutes Feet

Are you currently under medical supervision? YES NO

If yes, why? _____

Please circle all that apply

Currently Pregnant Past Pregnancies C-Sections

Allergies Skin Conditions Rashes/Irritations

Chronic Pain Autoimmune Disorder Arthritis

Asthma Spinal Disorders/Injuries TMJ Headaches

Cancer Heart Problems High/Low Blood Pressure

Diabetes Hypoglycemia Fainting Dizziness

Frequently tired Pain that radiates down leg/arm

Blood Thinners Antihistamines Pacemaker

Signs of Infection Other:_____

Surgeries/Procedures/Accidents/Imaging:

_____

_____

_____

Is there anything else that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you?

_____

_____

A few quick tips…

- Please do not hesitate to ask your therapist to adjust the pressure or technique, music, table or temperature at any time.
- You will be asked to undress to your comfort level. While muscles are easiest to work when they are uncovered, it is not required. If you choose to undress your therapist will use skilled draping techniques to protect your modesty at all times.
- We recommend using the restroom before your session.
- After your session, be sure to drink plenty of water and feel free to ask any questions you may have.
- Relax and enjoy!

(a) I will notify Resilience Massage and Wellness of any physical or health conditions that may impact the safety and effectiveness of my treatments. These include, but are not limited to, Currently Pregnant, Fever within the last 48 Hours, Kidney Disease, Deep Vein Thrombosis, Hemophilia, Cancer, Asthma, Taking Blood Thinners, Taking Antihistamines, Diabetes, Hypoglycemia, Skin Conditions/Rashes, Chronic Pain, Headaches, Pain that radiates down arm/leg, Spinal Injuries/Disorder(s), Autoimmune Disorder(s), High Blood Pressure, Low Blood Pressure, Allergies. I will notify my therapist of all changes in my health prior to each session

(b) I understand that massage therapy is not a substitute for medical care, and it is recommended I inform my primary caregiver that I am receiving bodywork.

(c) I understand that in no way will any part of my session be sexual, and I will not solicit or engage in such a manner.

(d) I understand that the therapy I am receiving is for relaxation, stress management, reduction of muscular tension, and other reasons discussed. Although the therapist may discuss possible treatment outcomes and goals, I understand that no promises or guarantees are being made.

(e) Resilience Massage and Wellness does not diagnose, prescribe medication or perform spinal manipulations.

(f) I understand my therapist may refuse service if I am under the influence of drugs or alcohol or for any reason the therapist feels massage is contraindicated.

(g) I understand that if I need to cancel, I will do so within **3 hours** of my scheduled service or I will be charged a $25 cancellation fee. If I do not show up to my scheduled appointment and do not attempt to notify the clinic, I will be charged 50% of the cost of my scheduled service(s) to compensate the therapist for their time. I understand that after my first “No Show”, I will be asked to leave a card on file and may be required to prepay for future appointments.

Signature of client _____ Date _____

FOR CLINIC USE

Practitioner Signature _____ Date _____

Review Date _____ Practitioner Signature _____