

# 4th Consciousness Initial Massage Therapy Intake Form

(All information will be kept confidential and will NOT be shared with any third parties except where required by law.)

**PLEASE FILL OUT CLEARLY AND COMPLETELY**

Name:		Date:
Address:		Referred by:
City:	Zip:	Birth Date:
Telephone (home):	(work):	(cell):
Email:		Occupation:
Preferred method(s) of contact (check all that apply): <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Regular mail		
Emergency Contact (name & relation):		Phone #:
Primary Healthcare Practitioner:		Phone #:
If this wasn't a referral, how did you hear about us? <input type="checkbox"/> internet <input type="checkbox"/> vehicle decal <input type="checkbox"/> massage event		
If you found us through the internet, please help us by specifying the site or search string:		

1. Have you had professional massage before? (If so, was it for anything specific?)
2. What are you hoping to gain from massage (e.g. relieve discomfort, reduce stress, etc)? (Please specify.)
3. What is your <b>major</b> concern today?
4. Are you currently under a healthcare practitioner's care? If yes, please describe.
5. Are you currently taking any medications, herbs, or other supplements? If so, please list and describe the condition. (Include over-the-counter products.)
6. Please circle your level of exercise:            Sedentary    Infrequent    Regular    Athletic
7. Please circle your most frequent activities at work and at home:  Sitting/Computer            Standing            Lifting            Walking            Phone
8. Please rate your overall stress level from 1 (least) to 10 (extreme). ____ How do you handle it?

9. Please list all **surgeries, serious illnesses, accidents or broken bones, other hospitalizations, and/or other injuries**, and the approximate month and year they occurred.

Event:

Mo / Yr:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

10. Please initial or put a check by **all** areas that you **consent to be massaged**. Any area(s) may be left blank at your discretion, and those areas will **not** be massaged. Please ask if you have any questions or are uncertain about any area.

Area	Initial/Check
Scalp	
Face	
Back	
Arms	
Wrists	
Hands	
Knees	
Calves	
Ankles	
Feet	

Area	Initial/Check
Internal TMJ muscles	
Frontal Neck	
Back of Neck	
Upper Pectoral	
Abdominal	
Gluteal (buttocks)	
Hip Joint Area	
Adductors (inner thigh)	
Quadriceps (thigh)	
Hamstrings (back leg)	

11. Please list all allergies (especially to pollens, nuts, and seeds, sensitivities to heat and cold, and sensitivities to essential oils or lubricant additives. \_\_\_\_\_

\_\_\_\_\_

Please review this list and circle any ailments that apply:

diabetes	heart condition	ruptured/bulging/herniated disc
arthritis (which type? _____)	skin disorder* (which? _____)	autoimmune disorder
cancer	asthma	fatigue
stroke	uncontrolled high blood pressure	depression
headache	infectious conditions*	dizziness
pacemaker	artificial joints (which? _____)	rods/pins (where? _____)
fibromyalgia	pregnant (trimester? _____)	TMJ
sciatica	migraines	HIV/AIDS/Hep C*
scoliosis	osteoporosis	phlebitis

Explanations, or Other Condition(s): \_\_\_\_\_

\*NOTE: Please be truthful; having one of these conditions does NOT necessarily prevent you from receiving therapy.

However, I NEED this information so that I may make adjustments to prevent contracting or spreading the disease.

## CONSENT FOR CARE (please read carefully)

I understand that massage therapy is not a substitute for primary medical treatment and that I should consult a chiropractor, physician, or other qualified medical specialist for any mental or physical ailment that I'm aware of.

I understand that massage therapy is not appropriate for all conditions, and that a referral from a primary healthcare provider may be required prior to service being provided.

I will immediately inform my therapist of any unusual sensation or discomfort, so that the application of pressure may be adjusted to my level of comfort.

Manual therapy will be given as agreed upon by therapist and client for the predetermined goals of relief of muscular discomfort, stress reduction, and/or promotion of health. I've been given the opportunity to ask questions.

I agree to provide the therapist with complete and accurate health information, and it is my responsibility as a client to update the therapist with any changes.

I understand that massage therapy is NOT sexually oriented in any way and that any illicit or suggestive remarks or actions on my part will result in immediate termination of the session, with the full balance due.

The unclothed body will be properly draped at all times.

I understand that by signing this form, I give my consent to receive the treatment discussed in this and all future sessions and I agree that my scheduling of future sessions shall be construed to be validation of this consent.

I have read this form and I understand it, and hereby freely give my permission to be massaged.

Signature of client: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent (if client is under 18): \_\_\_\_\_