MASSAGE INTAKE FORM

RAQUEL CARTER

LICENSED MASSAGE THERAPIST
EXERCISE PHYSIOLOGIST
REFLEXOLOGIST

CLIENT INFORMATION

NAME:_____DATE: _____
Last First Middle Initial

BIRTHDAY:_____MARITAL STATUS: S__M__W__D__DP__

ADDRESS:_____
Street and /or Apartment # City State Zip Code

HOME PHONE: _____ CELL PHONE: _____

EMPLOYER: _____WORK PHONE:_____

MASSAGE HISTORY

How often have you received a massage in the past?

_____Never _____Time(s)a week _____Time(s) a month _____Times a year

When was your last massage?_____

*What did you like most about your previous massage? Why? _____

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*What did you least like about your previous massage? Why? _____

_____

*Are you sensitive to (circle all that apply) oils lotions scents (If so please explain)

_____

*** IF APPLICABLE**

MEDICAL HISTORY

Tell Me What's Bothering You Today: _____

How long has this bothered you? ____ Week(s) ___Month(s) ___ Year(s) ___(Not Sure)

What activities aggravate/elevate this condition? _____

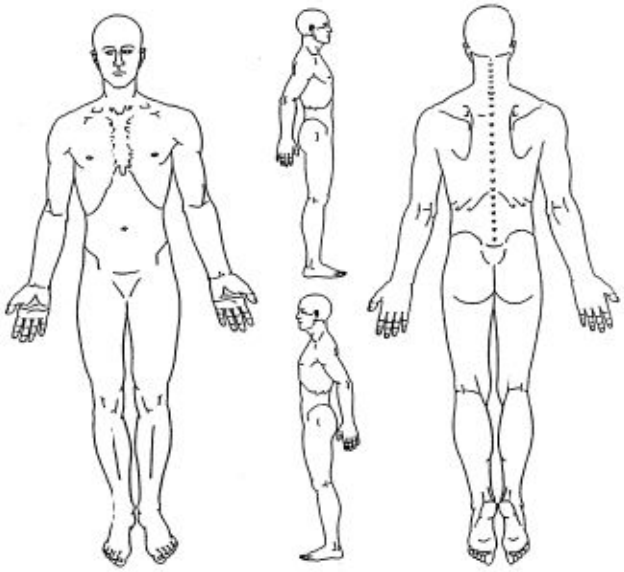
What activities improve/relieve this condition? _____

Are you under any medical/therapeutic treatment? _____Yes ____No

If Yes, Explain: _____

Do you have any artificial joints, plates, screws, etc.? ____Yes ____ No
Have you had any recent surgeries? ____ Yes ____ No
Have you had any recent injuries? ____ Yes ____ No
Have you been in a car accident in the last two years? ____ Yes _____ No

Mark an "X" on the diagram to the right to indicate your Area's of pain.



Mark an "X" to represent your level in each

Health Low _____High

Energy Low _____High

Stress Low _____High

MASSAGE THERAPY INFORMED CONSENT

I, _____(client) understand that massage therapy provided by, Raquel N. Carter C.M.T. (massage therapist) is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes for massage therapy are specified below:

_____NONE_____

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medication, and that spinal manipulations are not part of massage therapy**.**

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

I have received a copy of the therapist's policies; I understand them and agree to abide by them.

Client Signature: _____

Date: _____

*Please do not sign this form if you have NOT read and understand the office policies. By signing this form, you will be responsible for possible fees or other charges applicable.

Health History

Musculo-Skeletal
*Headaches
*Joint stiffness/swelling
*Spasms/cramps
*Broken/fractured bones
*Strains/sprains
*Back, hip pain
*Shoulder, neck, arm, hand pain
*Leg, foot pain
*Chest, ribs, abdominal pain
*Problems walking
*Jaw pain/TMJ
*Tendonitis
*Bursitis
*Arthritis
*Osteoporosis
*Scoliosis
*Bone or joint disease
*Other: _____

Circulatory & Respiratory
*Dizziness
*Shortness of breath
*Fainting
*Cold feet or hands
*Cold sweats
*Swollen ankles
*Pressure sores
*Varicose veins
*Blood clots
*Stroke
*Heart condition
*Allergies
*Sinus problems
*Asthma
*High blood pressure
*Low blood pressure
*Lymphedema
*Other: _____

Skin
*Rashes
*Allergies
*Athlete's Foot
*Warts
*Moles
*Acne
*Cosmetic Surgery
*Other: _____

Digestive
*Nervous stomach
*Indigestion
*Constipation
*Intestinal gas/bloating
*Diarrhea
*Diverticulitis
*Irritable bowel syndrome
*Crohn's Disease
*Colitis
*Other:_____

Nervous System
*Numbness/tingling
*Twitching of face
*Fatigue
*Chronic pain
*Sleep disorders
*Ulcers
*Paralysis
*Herpes/shingles
*Cerebral Palsy
*Epilepsy
*Chronic Fatigue Syndrome
*Tremors
*Multiple Sclerosis
*Muscular Dystrophy
*Parkinson's disease
*Spinal cord injury
*Other:_____

Reproductive System
*Pregnancy
*Current *Previous
*PMS
*Menopause
*Pelvic Inflammatory Disease
*Endometriosis
*Hysterectomy
*Fertility concerns
*Prostrate problems

Other:
*Loss of appetite
*Forgetfulness
*Confusion
*Depression
*Difficulty concentrating
*Drug use
*Alcohol use
*Nicotine use
*Adaptive aids
*Caffeine use
*Hearing impaired
*Visually impaired
*Burning upon urination
*Bladder infection
*Eating disorder
*Diabetes
*Fibromyalgia
*Post/Polio Syndrome
*Cancer
*Infectious disease (please list)
_____
*Other congenital or acquired disabilities (please list)
_____
*Surgeries _____
*Other: _____

For clients who need mobility assistance, please give your height: _____weight_____

Please list any additional comments regarding your health & well-being: _____

_____

Policies and Procedures

The following policies are to help everyone get the best treatment possible. Please read them carefully and ask if you have any questions.

1. **There is a 24 hour cancellation policy**. As standard policy in the industry, and courtesy to your therapist(s), if you are unable to make your scheduled appointment, please call at least 24 hours prior to your appointment to cancel or re-schedule. This will help insure that spot will be available for those who may other wise be in need of your time slot. If you fail to allow for a 24 hour notice, a $**30.00 fee** will be assessed to your account and will be expected at time of next service.

2. **Please arrive on time**. This is very important because the therapist(s) wants to be able to give you your full session time, as well as, there may be another appointment following your session. **To help keep all massages starting on time, please arrive on time, or 5 minutes early to allow for extra time if needed (restroom, weather conditions, etc.)** If you are late and there is another appointment following yours, know that the therapist(s) may not be able to give you our full schedule time. If you receive a shorter massage than scheduled due to a late arrival, please understand you will be expected to pay for a full session.

3. **Payment due at time of service**. Payment for a massage will be expected at the time of service. Please be prepared to do so. Your therapist has the right to charge a **late fee of $5.00** to any payment not received on the day of service. If you are unable to pay for our service please inform your therapist so that a payment arrangement can be made and you can avoid a late fee.

4. **Right to refuse service**. The therapist(s) have full rights to refuse service to any person(s), even if you have received a treatment in the past. Please understand that massage therapy is a healing therapy and if the therapist(s) should feel that they are unable to treat a person to the best of their ability, or should feel uncomfortable treating a person for ANY reason, they can refuse any or all treatment(s).

5. **There are NO exceptions to these policies**. If you feel you should be exempt from one or more of these policies than please inform your therapist before signing the consent form. Your signature confirms your understanding, and your willingness to follow these policies and pay any fees applicable.

Please note that the therapist(s) here are independent and are not paid an hourly wage. Activa is not responsible for covering "payments due" to the therapist by the clients. To help ensure our therapist's time is valued, please follow the listed policies. Your cooperation is greatly appreciated.

*****PLEASE KEEP THIS COPY FOR YOUR RECORDS.**