

## ***Confidential Client Health Intake Form***

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone:(day) \_\_\_\_\_ (evening) \_\_\_\_\_ (cell) \_\_\_\_\_

Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship \_\_\_\_\_

Physician Name \_\_\_\_\_ Can we contact if needed? \_\_\_\_\_

Phone / Address of physician \_\_\_\_\_

Referred by: \_\_\_\_\_ (so we can thank them w/ a massage)

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***Please answer these questions as accurately as possible. It is important for the massage***

Have you ever received a massage? \_\_\_\_\_ If yes, how frequent do you receive them: \_\_\_\_\_

What is the reason for today's massage session? \_\_\_\_\_

Please list and describe any physical or stress reduction activities: \_\_\_\_\_

Do you have: Cold, Flu, Fever, areas of Infection or Inflammation? \_\_\_\_\_

Are you under the care of a physician or have any diagnosed conditions? \_\_\_\_\_

If yes, please describe \_\_\_\_\_

List any current medication or supplements used : \_\_\_\_\_

Please list any surgeries, injuries, or areas of severe pain: \_\_\_\_\_

Do you have any chronic, ongoing pain that you deal with on a regular basis? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Please list any areas of tension, tight muscles, or areas of focus: \_\_\_\_\_

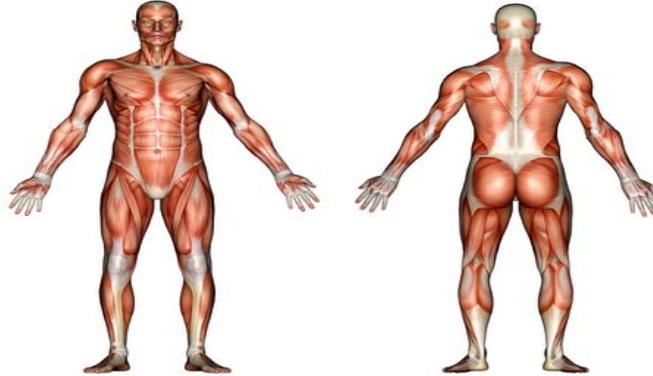
Please list any areas you would like avoided: (bruises, open wounds, ticklish areas, tender areas, etc.) \_\_\_\_\_

Are you pregnant? \_\_\_\_\_ If yes, for how long? \_\_\_\_\_

Are you wearing contacts? \_\_\_\_\_ Dentures? \_\_\_\_\_ IV Ports? \_\_\_\_\_

Transdermal patches (birth control/nicotine) \_\_\_\_\_ where? \_\_\_\_\_

Please indicate where you experience pain/tension on the drawing below



Are you currently experiencing any of the following conditions?

\_\_\_\_\_ Flu or Cold \_\_\_\_\_ Inflammation \_\_\_\_\_ Fever \_\_\_\_\_ Infection \_\_\_\_\_ Contagious Disease

Please check any of the following conditions below that currently affect you or that you have experienced in the past:

**MUSCULOSKELETAL**

- \_\_\_\_\_ Fibromyalgia
- \_\_\_\_\_ Spasms/Cramps
- \_\_\_\_\_ Sprains/Strains
- \_\_\_\_\_ Osteoporosis
- \_\_\_\_\_ Postural Deviations
- \_\_\_\_\_ Gout
- \_\_\_\_\_ Osteoarthritis
- \_\_\_\_\_ Rheumatoid Arthritis
- \_\_\_\_\_ TMJ
- \_\_\_\_\_ Cysts
- \_\_\_\_\_ Bursitis
- \_\_\_\_\_ Plantar Fasciitis
- \_\_\_\_\_ Tendonitis
- \_\_\_\_\_ Torticollis
- \_\_\_\_\_ Whiplash Syndrome
- \_\_\_\_\_ Carpal Tunnel Syndrome
- \_\_\_\_\_ Sciatica
- \_\_\_\_\_ Thoracic Outlet Syndrome
- \_\_\_\_\_ Headache
- \_\_\_\_\_ Neck Pain
- \_\_\_\_\_ Arm Pain
- \_\_\_\_\_ Shoulder Pain
- \_\_\_\_\_ Upper Back Pain
- \_\_\_\_\_ Mid Back Pain
- \_\_\_\_\_ Low Back Pain
- \_\_\_\_\_ Leg Pain
- \_\_\_\_\_ Hip Pain
- \_\_\_\_\_ Other \_\_\_\_\_

**RESPIRATORY**

- \_\_\_\_\_ Pneumonia
- \_\_\_\_\_ Emphysema
- \_\_\_\_\_ Asthma
- \_\_\_\_\_ Difficulty Breathing
- \_\_\_\_\_ Allergies
- \_\_\_\_\_ Other \_\_\_\_\_

**CIRCULATORY**

- \_\_\_\_\_ Anemia
- \_\_\_\_\_ Hemophilia
- \_\_\_\_\_ Hypertension
- \_\_\_\_\_ Low Blood Pressure
- \_\_\_\_\_ Raynaud's Disease
- \_\_\_\_\_ Varicose Veins
- \_\_\_\_\_ Heart Condition
- \_\_\_\_\_ Blood Clots/Phlebitis
- \_\_\_\_\_ Diabetes
- \_\_\_\_\_ Other \_\_\_\_\_

**DIGESTIVE**

- \_\_\_\_\_ Ulcers
- \_\_\_\_\_ Irritable Bowel Syndrome
- \_\_\_\_\_ Colitis
- \_\_\_\_\_ Gallstones
- \_\_\_\_\_ Hepatitis
- \_\_\_\_\_ Crohn's Disease
- \_\_\_\_\_ Celiac Disease
- \_\_\_\_\_ Diarrhea
- \_\_\_\_\_ Constipation
- \_\_\_\_\_ Gas/Bloating
- \_\_\_\_\_ Indigestion
- \_\_\_\_\_ Other \_\_\_\_\_

**SKIN**

- \_\_\_\_\_ Fungal Infection
- \_\_\_\_\_ Acne
- \_\_\_\_\_ Impetigo
- \_\_\_\_\_ Dermatitis
- \_\_\_\_\_ Eczema
- \_\_\_\_\_ Psoriasis
- \_\_\_\_\_ Open Wound/Sore
- \_\_\_\_\_ Rash
- \_\_\_\_\_ Warts/Moles
- \_\_\_\_\_ Athlete's Foot

**NERVOUS SYSTEM**

- \_\_\_\_\_ ALS
- \_\_\_\_\_ Multiple Sclerosis
- \_\_\_\_\_ Parkinson's Disease
- \_\_\_\_\_ Bell's Palsy
- \_\_\_\_\_ Neuritis
- \_\_\_\_\_ Spinal Cord Injury
- \_\_\_\_\_ Stroke
- \_\_\_\_\_ Trigeminal Neuralgia
- \_\_\_\_\_ Seizure Disorders
- \_\_\_\_\_ Numbness/Tingling/Twitching
- \_\_\_\_\_ Dizziness
- \_\_\_\_\_ Vertigo
- \_\_\_\_\_ Tinnitus(Ringing in the ears)
- \_\_\_\_\_ Other \_\_\_\_\_

**OTHER**

- \_\_\_\_\_ Insomnia
- \_\_\_\_\_ Anxiety/Panic Attacks
- \_\_\_\_\_ PMS
- \_\_\_\_\_ Grief Process
- \_\_\_\_\_ Cancer
- \_\_\_\_\_ Chronic Fatigue
- \_\_\_\_\_ HIV/AIDS
- \_\_\_\_\_ Lupus
- \_\_\_\_\_ Kidney Disease
- \_\_\_\_\_ Bladder Infection
- \_\_\_\_\_ Edema
- \_\_\_\_\_ Postoperative Situation
- \_\_\_\_\_ Other \_\_\_\_\_

The above information is accurate and true to the best of my knowledge. I understand that Massage Therapists do not diagnose disease, prescribe medications or manipulate bones. I understand that Massage Therapy can be beneficial and therapeutic, but may be contraindicated for certain medical conditions, and that it is not a substitute for medical attention. I take full responsibility for alerting my practitioner to any physical, mental, or emotional changes related to my health. I take full responsibility for disclosing any medical information that is important to the session (including if I am under the influence of prescription, over-the-counter, or illegal drugs, and/or alcohol). I also understand that Massage Therapists are not liable for any complications that may occur due to poor health or any undisclosed medical information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Cancellation Policy

Welcome to Albany Massage Professionals

We are a small business and occasionally appointment openings can be limited. In order to provide you with the best service possible and access to appointments during busy times, we have a strict 24 hour cancellation policy.

## **Cancellations**

24 hours notice for cancellations is required. Since we turn away other clients to hold your reservation, any cancellation with less than 24 hours notice will be charged the full amount of the session.

## **Late Arrivals**

We realize that tardiness is sometimes out of your control. We will do our best to provide you with the best treatment possible in the time remaining. If your tardiness causes the original appointment length to be shortened, please note that you will be charged for the length of the original appointment time (Example: If a one hour (60 minute) session is ultimately reduced to a half hour (30 minute) session, you will be charged the amount of a one hour (60 minute) session).

I acknowledge that I have read and agree to abide by the terms of this policy.

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Signature

Date