saratoga holistic massage

Massage Intake

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Cell Phone: _____ Home Phone: _____

DOB: _____ Occupation: _____

In order to properly perform your medical massage and to avoid possible contraindications, please list ALL health issues, including surgeries, conditions, and treatment plans either diagnosed or prescribed within the last three years.

_____

_____

In case of emergency, contact: _____ Phone: _____

Are you taking any prescriptions? Please list all. _____

_____

Are you under the care of a doctor or physician? _____ If yes, Dr. name and phone: _____

Allergies? Please list all. _____

How many hours do you sleep on average? _____ Please rate your stress level 1-10 _____ Does stress affect you negatively in any of the following ways? Digestion: Yes / No Muscle Tension: Yes / No Skin: Yes / No Sleep: Yes / No

Have you ever had a professional massage? _____ If yes, approximate date of last massage? _____

Whom may we thank for referring you to us? _____

Do you have any of the following conditions? Please check if yes and explain if necessary.

___ Fever, flu or infection	___ Tendonitis	___ Immune system conditions
___ Heart Condition	___ Blood clots	___ Skin rashes/acne/eczema
___ High or low blood pressure	___ Stress	___ Surgery within the past year
___ Migraines	___ Hepatitis A, B or C	___ Kidney or urinary issues
___ Pregnancy	___ Insomnia	___ Arthritis
___ Neck Pain	___ Asthma/Bronchitis	___ Epilepsy
___ Upper Back Pain	___ Broken Bones	___ Seizures
___ Middle Back Pain	___ Cancer or tumors	___ Diabetes
___ Lower Back Pain	___ Ulcers or digestive issues	___ Other: _____

Explanation: _____

_____

_____

Please read and sign to acknowledge: I have stated all of my known medical conditions on this intake form and I have consulted a licensed medical health care practitioner regarding these conditions. It is my responsibility to make my practitioner aware of any change(s) in my health status. I understand massage services are a complimentary aid to my well-being and are not substitutes for medical care. Therefore, I release and discharge Saratoga Springs Massage Therapy LLC from any and all claims or causes of action arising out of or relating to massage services. Any information provided to you by the practitioner is for educational purposes only and is not diagnostic. Either party reserves the right to end a session at any time. 100% of a service's cost is charged for any no-shows, cancellations with less than 24 hours notice, or if you arrive late to your appointment.

Client Signature: _____ Date: _____