Diana Remaley Massage Therapy

Client Intake Form

Name:_____ Date:_____
Address (Street, city, state):_____
Phone:_____ Date of Birth: _____
Email:_____
Occupation:_____
Posture assumed most of the day (standing/seated/etc.):_____
Are you presently experiencing any pain or discomfort?_____
_____
Have you previously received a professional massage? _____
(Describe any relevant details)_____
How did you hear about this office? (Website, referral, etc.) _____

Habits

Exercise_____
Tobacco_____Alcohol_____Caffeine_____
Sleep_____Drugs (non-prescription)_____

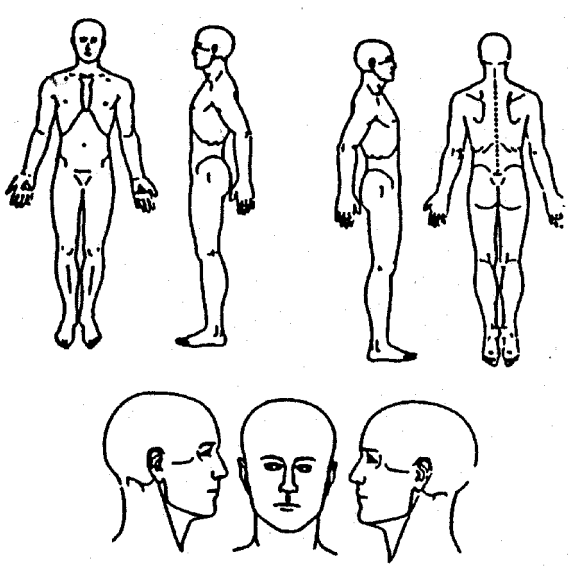
Do you experience any difficulty lying on your back or stomach? _____

Have you consumed any narcotics in the past 24 hours?
_____

Are you currently taking any prescription medication?
_____
Please list:_____

Please describe the condition for which it was prescribed:
_____

Please mark any area where you are experiencing pain or discomfort



Medical History

Please indicate if you are presently experiencing or have experienced any of the following conditions:

_____Skin condition (acne, rash, psoriasis, allergies, warts, Botox, other) _____
_____All allergies: Please specifically list _____
_____Diabetes
_____High or low blood pressure
_____Asthma
_____Cancer (Please list type and date) _____
_____Thyroid condition (please specify)_____
_____Lymphatic condition (swollen glands, lymphedema, lymphoma, etc.)
_____Recent injury or accident (whiplash, sprain, strain, etc.)
_____Circulatory Condition (heart disease, varicose veins, phlebitis, arrhythmia, atherosclerosis, etc.)
_____Neurological Condition (sciatica, numbness/tingling, stroke, epilepsy, etc.)
_____Joint problems, pain, stiffness, (arthritis, gout, hypermobility, etc.)
_____Bone condition (previous fracture, cancer, etc.)

Over Please

_____Headaches (migraines, tension, PMS, cluster, sinus, etc.)
_____Emotional difficulties (depression, anxiety, etc.)
_____Stress
_____Digestive disorders (Crohn's disease, IBS, constipation, etc.)
_____Previous surgery (please list type and date) _____
_____Any other medical condition (please specify) _____
_____Are you pregnant?

Primary Health Care Provider:_____
PCP Address:_____
PCP Phone:_____
Permission to Contact PCP? If yes, please initial_____

Emergency Contact Name/Relationship:_____
Emergency Contact Phone:_____

Agreements and Acknowledgments

I understand that massage therapy provided is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch.

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 Health Care Provider for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I understand that there are remote risks associated with massage therapy. I acknowledges that the massage therapist is not liable for any injury resulting from unreported conditions and/or concerns.

I acknowledge that massage therapy performed is strictly non-sexual and that proper draping techniques will be observed at all times. I also acknowledge that appropriate hygiene will be maintained at all times in office.

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

I understand that a cancellation fee in the amount of fifty percent (50%) of the total full price cost for my session will be charged in the event that I cancel my appointment with less than twenty four (24) hours' notice.

COVID-19: I do not have a pending Covid-19 test. I have not, nor has anyone in my household, nor has anyone with whom I've been in close contact, experienced any symptoms of Covid-19 in the past 14 days. (Fever, cough, difficulty breathing, unexplained rash, etc.) I acknowledge that Diana Remaley Massage Therapy is following all state-mandated guidelines for safe practice. I hold Diana Remaley Massage Therapy harmless if I contract Covid-19.

I have read and understand this document.

Client
Signature_____ Date_____