MASSAGE CLINIC INTAKE FORM

To maximize the effectiveness of your massage session, please carefully fill out this form. All information will be treated confidentially. Your comfort and safety are our primary concern.

Personal Information

Print Name: _____ Date: _____

Address: _____ Cell #: _____

City / State / Zip: _____ Age: _____ *(must be at least 18 years old)*

Email: _____ Occupation: _____

Hobbies / Physical Activities: _____

Primary Health Care Provider:

Name: _____

Phone: _____

Person to Contact in Case of an Emergency:

Name: _____

Phone: _____

CLINIC AGREEMENT - The undersigned agrees to the following:

- I understand that the massage practitioners are current **STUDENTS** of the De Anza Massage Program and that the intent of this program is to help students further their education and abilities in the art and science of massage therapy.
- **I acknowledge that the intent of the massage is not to diagnose or treat illnesses.** I am solely responsible for my physical condition and for seeking medical treatment when necessary.
- Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to ANY changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.
- Appointment Etiquette - I will: arrive 15 minutes early, bring proper payment, bring swimsuit or wear appropriate undergarments (no nudity allowed), shower, not wear perfume/cologne, turn OFF all electronics, cancel appointments AT LEAST 24 hours in advance.
- Late arrivals – If I am more than 5 minutes late, I can be considered a "No Show" and my appointment may be given to another available client. If the appointment time is still open, I will receive only the remaining time of the massage, not the full 45 minutes.
- No Shows – If I have 2 (two) no shows, the massage clinic will revoke my right to be a client.

Signature:_____ **Date:** _____

History

Have you received a professional massage before? ❑ **Y** / ❑ **N**

If yes, what type?_____ How long ago? _____

Do you now have (current) or have you ever had (previous) any of the following:

Current / Previous	Condition
❑ / ❑	Allergies:_____
❑ / ❑	Arthritis - Osteoarthritis
❑ / ❑	Arthritis - Rheumatoid
❑ / ❑	Asthma / Respiratory
❑ / ❑	Back pain
❑ / ❑	Blood clots / Phlebitis
❑ / ❑	Blood pressure: high / low
❑ / ❑	Bruise easily
❑ / ❑	Cancer / tumors
❑ / ❑	Cold / Flu
❑ / ❑	Chest pain
❑ / ❑	Depression
❑ / ❑	Diabetes
❑ / ❑	Diarrhea / constipation
❑ / ❑	Disc problems
❑ / ❑	Dizziness
❑ / ❑	Fatigue
❑ / ❑	Fibromyalgia
❑ / ❑	Foot problem
❑ / ❑	Headaches (migraine)
❑ / ❑	Headaches (tension)
❑ / ❑	Heart disease
❑ / ❑	Hepatitis
❑ / ❑	Hernia: _____
❑ / ❑	Immune system conditions
❑ / ❑	Insomnia
❑ / ❑	Irritability / stress
❑ / ❑	Lymph node removal
❑ / ❑	Muscle cramps / spasms
❑ / ❑	Neck Pain
❑ / ❑	Numbness/ tingling
❑ / ❑	Osteoporosis
❑ / ❑	PMS (Premenstrual syndrome)
❑ / ❑	Pacemaker / defibrillation
❑ / ❑	Poor posture
❑ / ❑	Rashes
❑ / ❑	Skin condition:_____
❑ / ❑	Stroke
❑ / ❑	Scoliosis
❑ / ❑	Sinus conditions
❑ / ❑	Tendonitis
❑ / ❑	Tremors
❑ / ❑	Varicose veins
❑ / ❑	Vertigo
❑ / ❑	Other: _____

Continued on back →

Are you pregnant or could you be pregnant? ❑ **Y** / ❑ **N** *(we do not perform massage on pregnant women)*

Are you currently under the care of a health practitioner? ❑ **Y** / ❑ **N**

If yes, please explain: _____

Please list current medications (write "none" if applicable):

_____

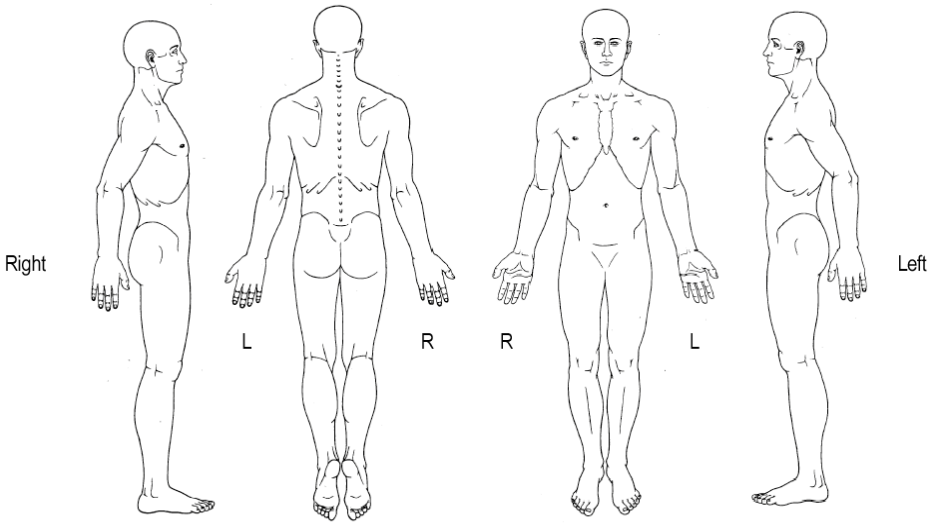
Have you been hospitalized or had surgery within the past 2 years? ☐ **Y** / ☐ **N**

If yes, please explain: _____

Have you had any **recent injury** or **serious illness**? ☐ **Y** / ☐ **N**

If yes, please explain: _____

Please circle the area(s) on the diagrams below where you are experiencing muscle and/or bodily discomfort and/or pain:



What are your goals for this massage? _____

Which areas require extra focus?_____

Which areas would you like avoided?_____

Depth of massage pressure preferred ❑ Light ❑ Moderate ❑ Firm

Do you have difficulty lying on your ❑ Back ❑ Abdomen ❑ Right Side ❑ Left Side

Therapist Notes:

_____

_____

_____

_____

_____