

# **LIVE LIFE NOW WELLNESS CENTER**

## **MASSAGE-NEW CLIENT INTAKE FORM**

### **PERSONAL INFORMATION:**

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Is this your permanent residence? Yes / No If not, where else do you live? \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

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

Leave Appointment Messages on: (Circle one) Home Cell Work Text Don't leave messages

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male / Female Age: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

**The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.**

### **TODAY'S DATE** \_\_\_\_\_

1. Have you had a professional massage before? Y / N

2. Do you have any difficulty lying on your front, back or side? Y / N

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

3. Do you have any allergies to oils, lotions or ointments? Y / N

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

4. Do you have sensitive skin? Y / N

5. Is there a particular area of your body where you are experiencing tension, stiffness, pain or other discomfort? Y / N

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

### **MEDICAL HISTORY:**

6. Are you currently under medical supervision? Y / N

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

7. Do you see a chiropractor? Y / N If yes how often? \_\_\_\_\_

8. Are you currently taking any medications? Y / N

If yes, please list all and explain \_\_\_\_\_

9. Please check any condition listed below that applies to you:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> contagious skin condition                                 | <input type="checkbox"/> phlebitis                  | <input type="checkbox"/> open sores or wounds   |
| <input type="checkbox"/> deep vein thrombosis / blood clots                        |   | <input type="checkbox"/> bruise easily          |
| <input type="checkbox"/> recent accident or injury                                 | <input type="checkbox"/> osteoporosis               | <input type="checkbox"/> recent fracture        |
| <input type="checkbox"/> epilepsy  | <input type="checkbox"/> recent surgery             | <input type="checkbox"/> headaches / migraines  |
| <input type="checkbox"/> artificial joints   | <input type="checkbox"/> cancer                     | <input type="checkbox"/> sprains / strains      |
| <input type="checkbox"/> diabetes  | <input type="checkbox"/> current fever              | <input type="checkbox"/> decreased sensation    |
| <input type="checkbox"/> swollen glands  | <input type="checkbox"/> TMJ                        | <input type="checkbox"/> back / neck problems   |
| <input type="checkbox"/> allergies / sensitivity                                   | <input type="checkbox"/> heart condition            | <input type="checkbox"/> circulatory disorder   |
| <input type="checkbox"/> Fibromyalgia  | <input type="checkbox"/> high or low blood pressure |   |
| <input type="checkbox"/> tennis elbow  | <input type="checkbox"/> varicose veins             | <input type="checkbox"/> carpal tunnel syndrome |
| <input type="checkbox"/> pregnancy   | <input type="checkbox"/> atherosclerosis            |   |
| <input type="checkbox"/> joint disorder / rheumatoid / osteoarthritis / tendonitis |   |   |

Please explain any condition you have marked above \_\_\_\_\_

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10. Is there anything else about your health history that would be useful for the therapist to know in planning a safe and effective massage for you? \_\_\_\_\_

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Clients under the age of 18 must be accompanied by a parent or legal guardian. This is considered an informed written consent and must be signed by the parent or legal guardian for any client under the age 18 to have a massage..

If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and / or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for a medical examination, diagnosis or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any physical or mental ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnosis, prescribe or treat any physical or mental illness, and that nothing said during the course of the session given should be construed as such. Since massage therapy should not be performed with certain medical conditions, I affirm that I have stated all my known medical conditions, answered all question honestly and I have updated the therapist with any changes in my medical profile. I understand that there will not be any liability on the part of the therapist or Live Life Now Wellness Center, LLC for any reason. I acknowledge that if I arrive late my session will end at originally scheduled time so the client following me is not penalized. I also understand that any inappropriate remarks or advances made will result in the immediate termination of the session and will be responsible for full payment of your scheduled appointment.

**Signature of Client** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Therapist** \_\_\_\_\_ **Date** \_\_\_\_\_