

Moon Tide Massage

Client Intake

(The information on this form is kept confidential.)

Name _____ Date of Birth _____ Sex: ____M ____F

Address _____

Home Phone _____ Cell phone _____

Email address (will not be given out): _____

Have you ever received massage therapy? ____Yes ____ No

Type of massage received (Swedish, Shiatsu, Deep Tissue, etc.) _____

Do you participate in any regular sport or physical fitness activity? Please specify _____

Are you currently taking any medications? ____Yes ____ No

If so, please list medications and reason(s) for taking them: _____

Are you currently seeing a health care professional? ____Yes ____ No

If yes, please list doctor's name and reason for treatment: _____

Please review the following list and check those conditions that have affected your health, either recently or in the past.

Auto-Immune condition (AIDS, Fibromyalgia, Chronic Fatigue, Lupus, etc.)	Depression, panic disorder, other psychological condition
Diabetes	Diverticulitis
Broken/dislocated bones	Headaches, Migraines
Bruise easily	Heart conditions
Cancer	Chronic pain
High blood pressure	Back problems
Constipation or diarrhea	Insomnia
Arthritis	Muscle strain/sprain
Hepatitis (A, B, C, other)	Pregnancy
Skin conditions (specify)	Scoliosis
Stroke	Seizures
Surgery (specify)	Whiplash
TMJ disorder	Chemical dependency (alcohol, drugs)
Sinus trouble	ringing in ears or pain
Fainting/dizziness	Asthma
Muscle spasms	Irritability
Shortness of breath	Twitching of face
Loss of Memory	Neck pain
Blood Clots	Varicose Veins
Numbness/Tingling	Sciatica
Joint swelling	Osteoporosis
Do you bruise easily?	Cardiac or circulatory problems

If any of the above needs to be detailed, please elaborate (use back of page if necessary):

Do you have any of the following today:

<input type="checkbox"/>	Skin Rash	<input type="checkbox"/>	Cold/Flu
<input type="checkbox"/>	Severe Pain	<input type="checkbox"/>	Anything contagious
<input type="checkbox"/>	Injuries or Bruises	<input type="checkbox"/>	

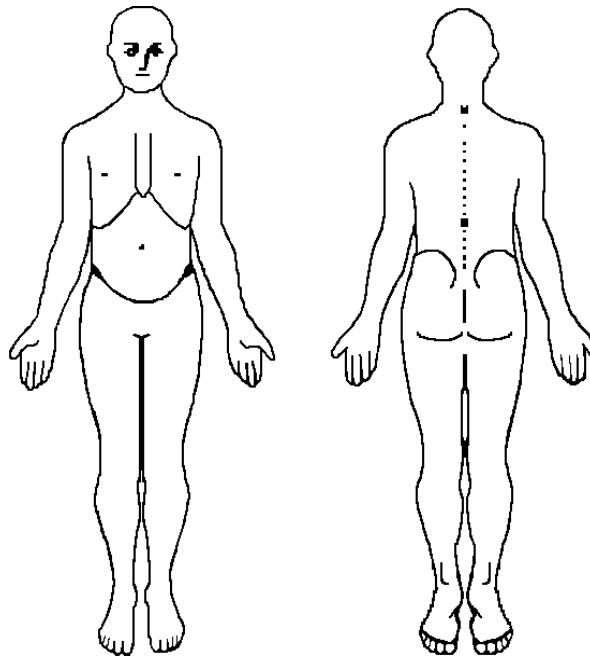
Do you have any allergies to:

<input type="checkbox"/>	Medications	<input type="checkbox"/>	Foods (Nuts, etc.)
<input type="checkbox"/>	Environmental allergens (dust, pollen, fragrances)	<input type="checkbox"/>	Reactions to skin care products

Please specify any other allergies: _____

Are you wearing: _____ Contact Lenses _____ Hearing Aid _____ Hairpiece/wig _____ Dentures

Please mark any areas, if any, where you are feeling pain or discomfort:



What are your goals/expectations for this therapy session? _____

The following sometimes occur during a massage. They are normal responses to relaxation. I would like your appointment to be as pleasant and comfortable as possible. If at any time, you

have questions or are uncomfortable regarding your session, please let me know. Communication is the key to a positive experience. Trust your body to express what it needs to:

- Need to move or change position
- Sighing, yawning, change in breathing
- Stomach gurgling
- Emotional feelings and/or expression
- Movement of intestinal gas
- Falling asleep
- Memories

Please read the following information and sign below:

- I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment. I understand that Massage Therapists do not diagnose illness, disease or any other physical or mental disorders.
- This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
- The massage therapist will not engage in breast massage. Genitals are ALWAYS excluded. Standard draping will be used, meaning only the body part being massaged will be exposed.
- I understand that massage should not be done under certain medical conditions. I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: _____ Date: _____