Healing Angels

Confidential Client Intake Form

Name_____ **Phone**_____ **e-mail**_____

Address_____**City/State/Zip**_____ **Occupation**_____

Date of Birth_____ **Emergency Contact** _____ **Phone**_____

Date of Initial Visit_____ **How did you hear about Healing Angels?**_____

How often do you receive professional massages?

❑ First Time ❑ Once a year or less ❑ 2-3 times/yr ❑ 4-6 times/yr ❑ 7-10 times/yr ❑ 11+ times/yr

What prevents you from receiving massages more frequently?

❑ Cost ❑ Time ❑ Other (specify reason _____)

Are you here today for:

❑ Headache ❑ Injury Rehab ❑ Relaxation ❑ Soreness ❑ Stress Relief ❑ General Health & Wellness

Medical Conditions – Please Check All That Apply:

❑ Arthritis	❑ Blood Pressure	❑ Diabetes	❑ Jaw Pain / TMJ	❑ Seizures
❑ Athletes Foot	❑ Bruise Easily	❑ Fibromyalgia	❑ Leg or Knee Pain	❑ Varicose Veins
❑ Blood Clots	❑ Cancer (active)	❑ Headaches	❑ Neck or Back Pain	❑ Warts
				❑ Numbness / Tingling

Please list any medications you are taking:

List any other medical conditions (including injuries or surgeries in last 2 years) that you think we should know about:

Are you pregnant?

❑ No ❑ Yes If yes, how many weeks? ___ Due Date: _____

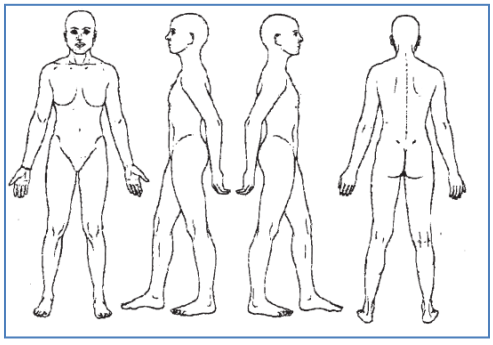
If yes, are you experiencing any of the following?

❑ Cramping/Soreness ❑ Pre-Eclampsia
❑ Morning Sickness ❑ Swelling (Edema)

Do you have any allergies or skin sensitivities?

❑ No ❑ Yes If yes, please list:

Circle any specific areas of your body you would like the massage therapist to concentrate on during the session:



Draping will be used during the session– only the area being worked on will be uncovered. Informed written consent must be provided by parent/legal guardian for any client under the age of 16.

I, _____(print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. 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 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, diagnose, prescribe, or treat any physical or mental illness. 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.

Signature of client_____ Date_____

Signature of Massage Therapist_____ Date_____