



Life 'n Balance

WELLNESS CENTRE

Massage Intake Form

How did you hear about Life 'n Balance? _____

Name: _____ Occupation: _____

Phone Number: _____ text reminders? Secondary Number: _____

Address: _____ Postal Code: _____

Email: _____ Date of Birth: _____

Emergency Contact (name and number): _____

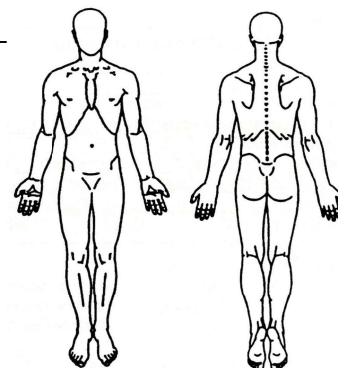
The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Date of Initial Visit: _____

1. Have you had a professional massage before? Yes No
If yes, how often do you receive massage therapy? _____
2. Do you have difficulty lying on your front, back, or side? Yes No
If yes, please explain _____
3. Do you have sensitive skin or allergies to oils, lotions, or ointments? Yes No
If yes, please explain _____
4. Are you wearing contact lenses , dentures , or a hearing aid ?
5. Do you sit for long hours at a workstation, computer, or driving? Yes No
If yes, please describe _____
6. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please describe _____
7. Do you experience stress in your work, family, or other aspect of your life? Yes No
If yes, how do you think it has affected your health?
muscle tension , anxiety , insomnia , irritability , other: _____
8. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No
If yes, please identify _____

9. Circle any specific areas you would like the massage therapist to concentrate on during the session.

10. Indicate on a scale of 10 the amount of pain you are experiencing.



1	2	3	4	5	6	7	8	9	10
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11. Do you see a chiropractor? Yes No

12. Do you have a medical doctor? Yes No

13. Are you currently taking any medications? Yes No

If yes, please list _____

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Recent accident or injury | <input type="checkbox"/> Recent fracture | <input type="checkbox"/> Recent surgery |
| <input type="checkbox"/> Sprains/strains | <input type="checkbox"/> Allergies/sensitivities | <input type="checkbox"/> Current fever |
| <input type="checkbox"/> Contagious skin condition | <input type="checkbox"/> Open sores or wounds | <input type="checkbox"/> Easy bruising |
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Circulatory disorder | <input type="checkbox"/> Heart condition |
| <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Decreased sensation | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Pregnancy (How many months: _____) | |

If yes, please explain _____

15. Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you?

16. Draping will be used during the session – only the area being worked on will be uncovered. Informed written consent must be provided by parent/guardian if under 18.

I, _____ 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 the session, I will immediately inform the therapist so that the pressure 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 mental or physical ailment that I am aware of. 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 or Life 'n Balance should I fail to do so.

Signature of Client: _____ Date: _____

Signature of Therapist: _____ Date: _____