Sole Therapy Massage intake form

Name _____ DOB _____

Address _____ City/state _____Zip_____

Contact Phone # _____ E-mail _____

Who may we thank for referring you? _____

Emergency Contact: Name/Phone _____

Medical Massage Only: Place of employment? _____

Date of Injury? _____ Where did the accident occur? _____

Doctor who refferred you? _____ Phone# _____

What area of the body are we addressing? _____

Your Body:

Have you ever experienced professional Massage?	Yes ( ) No ( )
Do you frequently experience stress?	Yes ( ) No ( )
Do you have Diabetes?	Yes ( ) No ( )
Do you experience frequent headaches?	Yes ( ) No ( )
Do you have joint swelling or suffer from arthritis?	Yes ( ) No ( )
Do you have high blood pressure?	Yes ( ) No ( )
Do you have varicose veins?	Yes ( ) No ( )
Do you have any contagious diseases?	Yes ( ) No ( )
Do you have Osteoporosis?	Yes ( ) No ( )
Do you have cardiac or circulatory problems?	Yes ( ) No ( )
Do you have numbness or stabbing pains?	Yes ( ) No ( )
Are you pregnant? If so how far along? _____	Yes ( ) No ( )
Any broken bones in the past two years?	Yes ( ) No ( )
Do you have trouble laying on your back or stomach?	Yes ( ) No ( )
Do you have any open sores or scabs?	Yes ( ) No ( )

What areas do you experience tension or soreness? _____

Please list current medications including blood thinners. _____

_____

Do you have any allergies to oils, fragrances, ect? If so, please list: _____

Please circle the type of pressure you prefer: Light Medium Firm

Please circle the massage modality you prefer: Relaxation Therapeutic

What problems are you having today? _____

I understand that the bodywork that I receive is provided for the purpose of relaxation and relief of muscular tension. If I experience pain or discomfort at any time during the session I will immediately inform my practitioner so that pressure may be adjusted to my comfort level. I agree to keep the practitioner updated with any changes to my medical profile and understand that there shall be no liability on the practitioners part should I fail to do so. I also understand that practitioner is not a physician and therefore unable to diagnose, prescribe or provide medical advise.

_____ Please initial on the line that you have read and acknowledge Sole Therapy's Policies.

_____ _____

Client Signature Date