Tranquility Massage & Bodywork
Kendra Heinrich - Certified Massage Therapist

Pleasant Co. Massage
Rachel Gutlovics – Certified Massage Therapist

Therapeutic Massage Patient Intake Form

Personal Information:

Name: _____Name you prefer to be called: _____

Phone: _____Address: _____City/State/Zip _____

Email: _____ Date of Birth: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

The following information will be used to help plan a safe and effective massage sessions.

Please answer the questions to the best of your knowledge.

1. Have you had a professional massage before? Yes No

   If yes, how often do you receive massage therapy? _____

2. Do you have any difficulty lying on your front, back or side? Yes No

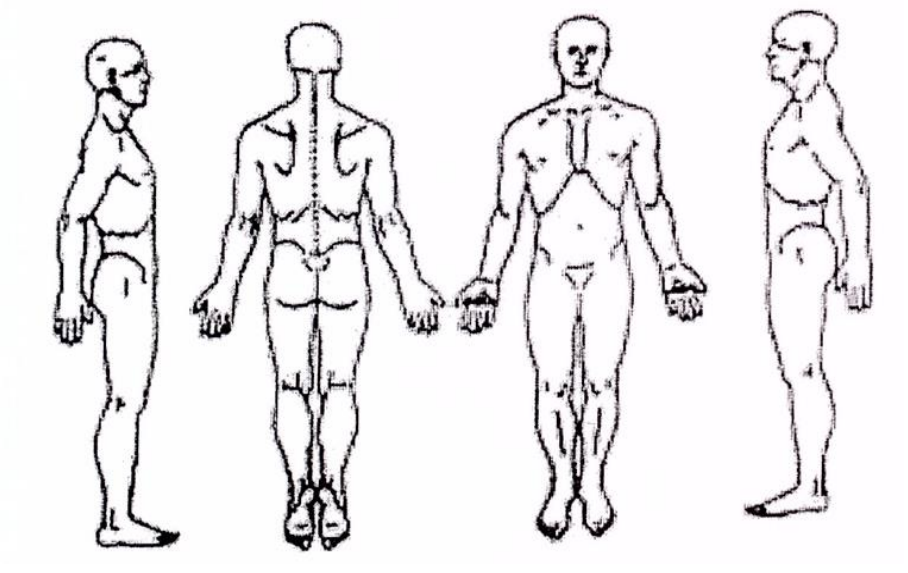
   If yes, please explain _____

3. Have you had any surgeries? If so, please explain _____
4. Do you have any allergies or sensitivities to oil, lotions or ointments? Yes No

   If yes, please explain _____

5. Do you sit for long hours at a workstation, computer, or driving? Yes No
   If yes, please explain _____
6. Do you perform any repetitive movement in your work, sports or hobby? Yes No
   If yes, please explain _____
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. Do you have any particular goals in mind for this massage session? Yes No
   If yes, please explain _____
10. How many cups of water do you drink per day? _____

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



<u>Medical History</u>- *In order to plan a massage session that is safe and effective, I need some general information about your medical history.

11. Are your currently under medical supervision? Yes No
    If yes, please explain _____
12. Do you see a Chiropractor? Yes No If yes, how often? _____
13. Are your currently taking any medication? Yes No
    If yes, please list _____
14. Please check any condition listed below that applies to you:

( ) contagious skin condition	( ) deep vein thrombosis/blood clots
( ) open sores or wounds	( ) easy bruising
( ) recent accident or injury	( ) varicose veins
( ) recent fracture	( ) osteoporosis
( ) artificial joint	( ) epilepsy
( ) sprains/strains	( ) headaches/migraines
( ) current fever	( ) cancer
( ) swollen glands	( ) diabetes
( ) allergies/sensitivity	( ) decreased sensation
( ) heart condition	( ) back/neck problems
( ) high or low blood pressure	( ) fibromyalgia
( ) circulatory disorder	( ) TMJ
( ) carpal tunnel syndrome	( ) tennis elbow

    ( ) pregnancy if yes, how many months? _____
    ( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
    Please explain any condition that you have marked above:
    _____
15. Is there anything else about your health history that you think would be useful for your massage therapist should know to plan a safe and effective massage session for you?
    _____

Draping will be used during the session – only the area being worked on will be uncovered. Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by a parent or legal guardian for nay client under the age of 17.

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief or 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 or 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. 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 in the course of the session given should be construed as such. 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: _____