Lotus Awakening Bodywork

Client Intake Form

Welcome! I would like to help create and facilitate a healing and comfortable session for you. If at any time you have questions, concerns, or need adjustments made (draping, pressure, positioning, etc.); please let me know as soon as they arise. Thank you kindly!

Personal Information

Name _____Email_____

Phone (Cell) _____Phone (Home)_____

Address _____

City _____State _____ Zip _____

Date of Birth _____Occupation _____

Emergency Contact _____Phone _____

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

Please answer the questions to the best of your knowledge.
Today's Date of Visit : _____

Have you had a professional massage before? Yes No
If yes, how often do you receive massage therapy?

_____

Do you have any difficulty lying on your front, back, or side? Yes No
If yes, please explain

_____

_____

Do you have any allergies to oils, lotions, or ointments? Yes No
If yes, please explain

_____

_____

Do you have sensitive skin? Yes No
If yes, please explain _____

_____

Are you wearing contact lenses, dentures, a hearing aid, or hairpiece? Yes No

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Do you sit for long hours at a workstation, computer, or driving? Yes No
If yes, please describe

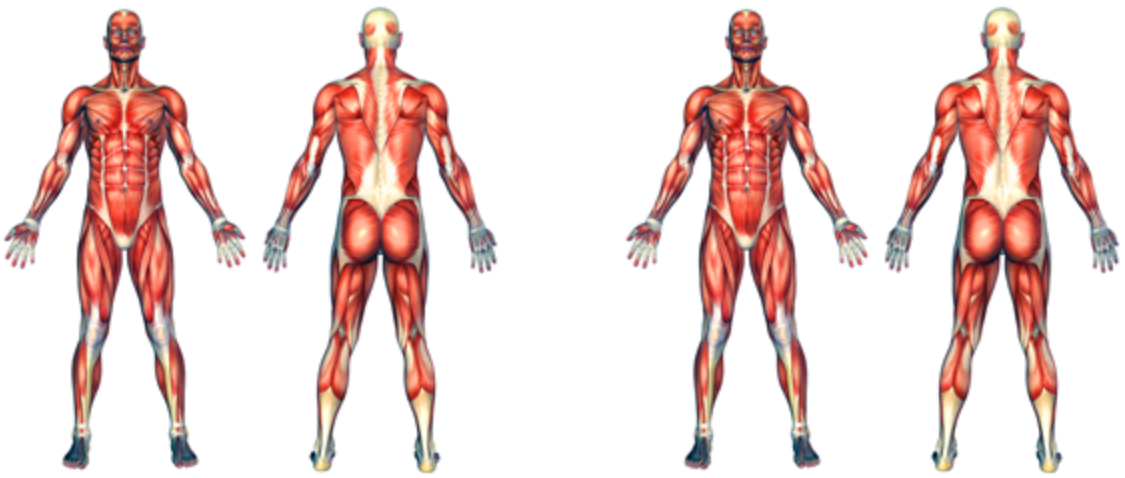
Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please describe

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

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No
If yes, please identify

Do you have any particular goals in mind for this massage session? Yes No
If yes, please explain

Circle any specific areas you would like the Licensed Massage Practitioner to concentrate on during your session today.



Medical History

In order to plan a massage session that is safe, effective, and healing; I will need some general information about your medical history.

Are you currently under medical supervision? Yes No
If yes, please explain

_____

_____

Do you see a chiropractor? Yes No If yes, how often?

_____

Are you currently taking any medication? Yes No
If yes, please list

_____

_____

Please check any condition listed below that applies to you:

contagious skin condition	phlebitis
edema	deep vein thrombosis/blood clots
easy bruising	joint disorder/rheumatoid
arthritis/osteoarthritis/tendonitis	recent accident or injury
osteoporosis	recent surgery
epilepsy	artificial joint
headaches/migraines	sprains/strains
cancer	current fever
diabetes	swollen glands
open sores or wounds	allergies/sensitivity
back/neck problems	scoliosis
whiplash	decreased sensation
insomnia	heart condition
auto-immune conditions*	high or low blood pressure
circulatory disorder	constipation/diarrhea
hepatitis(A,B,C,other)	TMJ dysfunction
carpal tunnel syndrome	thoracic outlet syndrome
tennis elbow	varicose veins
atherosclerosis	pregnancy if yes, how many months?

(*AIDS, fibromyalgia, chronic fatigue, lupus, etc…)

Please explain any condition that you have marked on the previous page.

_____

_____

Is there anything else about your health history that you think would be useful for your Licensed Massage Practitioner to know to plan a safe, effective, and healing massage session for you?

_____

_____

Draping will be used during the session – only the area being worked on will be uncovered. Please let me know as soon as possible if you are uncomfortable.

Informed written consent must be provided by parent or legal guardian for any client under the age 17.

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 massage 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 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, diagnose, 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. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session; I will be liable for payment of scheduled treatment. I also understand that the Licensed Massage Practitioner reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

Signature of client _____
Date _____

Signature of Licensed Massage Practitioner_____
Date _____