Body Heart & Sole Massage and Reflexology
Robin Smith LMBT #9798
Client Intake Form

Date_____

Name_____ Phone_____

Address_____

City/State/Zip_____

Email_____ Date of Birth_____

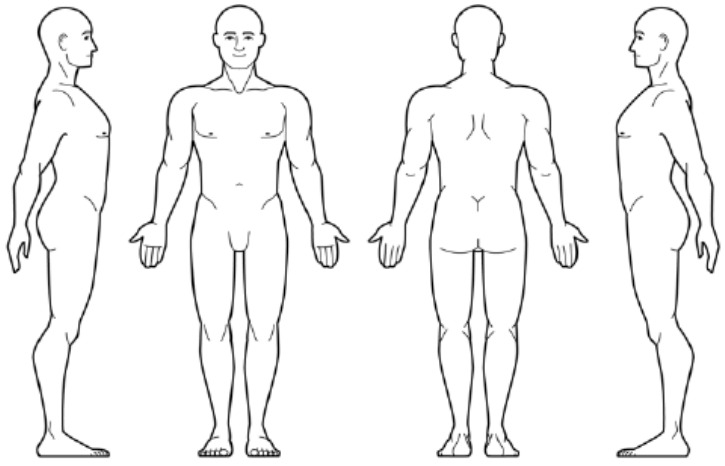
Occupation_____

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.

1. **Have you ever had a professional massage before? Yes _____ No _____**
   If yes, how long since your last massage?_____
2. **How did you hear about Body Heart & Sole Massage and Reflexology? _____**
3. **Do you have any difficulty lying on your front, back, or side? Yes_____ No_____**
   If yes, please explain._____
4. **Do you have any allergies to oils, lotions, or ointments? Yes_____ No_____**
   If yes, please explain._____
5. **Do you have sensitive skin? Yes_____ No_____**
6. **Do you wear Contact Lenses? ( ) Dentures? ( ) Hearing Aid? ( )**
7. **Do you prefer Quiet? ( ) Conversation? ( ) Moderate Conversation? ( )**
8. **What pressure do you like? Light ( ) Medium ( ) Firm ( )**
9. **Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes_____ No_____If yes, please explain._____**
10. **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 massage therapist to concentrate on during the session.



Medical History: In order to plan a massage session that is safe and effective, I need some general information about your medical history.

11. **Who is your primary care physician? _____**
12. **Do you see at chiropractor? Yes_____ No____If yes, how often?_____**
13. **Are you currently taking any medications? Yes_____ No_____**
    If yes, please list._____

    _____

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

____	**Contagious skin condition**	**____**	**Phlebitis**
____	**Open sores or wounds**	**____**	**Deep vein thrombosis/blood clots**
____	**Easy bruising**	**____**	**Joint disorder/rheumatoid arthritis**
____	**Recent accident or injury**	**____**	**Arthritis/osteoarthritis**
____	**Recent fracture**	**____**	**Osteoporosis**
____	**Recent surgery**	**____**	**Epilepsy**
____	**Artificial joint**	**____**	**Headaches/migraines**
____	**Sprains/strains**	**____**	**Cancer**
____	**Current fever**	**____**	**Diabetes**
____	**Swollen glands**	**____**	**Decreased sensation**
____	**Allergies/sensitivity**	**____**	**Back/neck problems**
____	**Heart condition**	**____**	**Fibromyalgia**
____	**High or low blood pressure**	**____**	**TMJ**
____	**Circulatory disorder**	**____**	**Carpal tunnel syndrome**
____	**Varicose veins**	**____**	**Tennis elbow**
____	**Atherosclerosis**	**____**	**Pregnancy If yes, how many months?___**

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? _____**

    _____

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 parent or legal guardian as well.

I, _____(print name) understand 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 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.

Signature of Client_____Date_____