

# The Colony Massage

## Client Intake Form

*All information will be kept confidential.*

Welcome to **The Colony Massage**. Please fill out all the information as accurately and thoroughly as possible. It is better that you give me too much information than not give me enough.

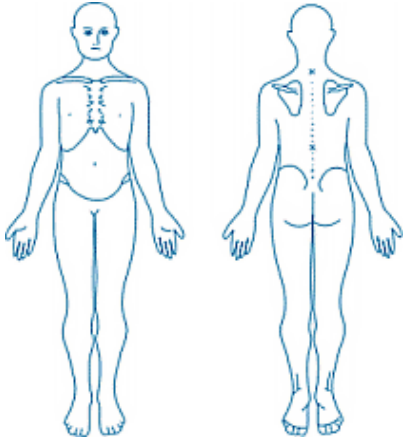
Name:		Date:
Address:		Referred by:
		Birth Date:
Home Phone:	Work:	Cell:
Email:		Would you like to be added to our email list? <input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Contact:	Relationship:	Phone #:
Employer:	Occupation:	Marital Status:

Have you ever received a massage before? If yes, when was your last massage?

Are you currently taking any medications? Please list them.

Describe any surgeries, hospitalizations, accidents or injuries you've had in the past 5 years:

Are there specific areas you would like me to focus on or stay away from?

<p>Please check any of the following which apply to you now or in the past:</p> <table border="0"> <tr> <td><input type="checkbox"/> arthritis</td> <td><input type="checkbox"/> back problems</td> </tr> <tr> <td><input type="checkbox"/> diabetes</td> <td><input type="checkbox"/> high blood pressure</td> </tr> <tr> <td><input type="checkbox"/> blood clots</td> <td><input type="checkbox"/> insomnia</td> </tr> <tr> <td><input type="checkbox"/> broken/dislocated bones</td> <td><input type="checkbox"/> muscle strain/sprain</td> </tr> <tr> <td><input type="checkbox"/> bruise easily</td> <td><input type="checkbox"/> pregnancy</td> </tr> <tr> <td><input type="checkbox"/> cancer</td> <td><input type="checkbox"/> scoliosis</td> </tr> <tr> <td><input type="checkbox"/> chronic pain</td> <td><input type="checkbox"/> seizures</td> </tr> <tr> <td><input type="checkbox"/> constipation/ diarrhea</td> <td><input type="checkbox"/> whiplash</td> </tr> <tr> <td><input type="checkbox"/> auto-immune condition*</td> <td><input type="checkbox"/> circulatory problems</td> </tr> <tr> <td><input type="checkbox"/> hepatitis (A, B, C, or other)</td> <td><input type="checkbox"/> dizziness</td> </tr> <tr> <td><input type="checkbox"/> skin conditions</td> <td><input type="checkbox"/> heart condition</td> </tr> <tr> <td><input type="checkbox"/> stroke</td> <td><input type="checkbox"/> frequent headaches/migraines</td> </tr> <tr> <td><input type="checkbox"/> TMJ disorder</td> <td><input type="checkbox"/> diverticulitis</td> </tr> <tr> <td><input type="checkbox"/> depression, panic disorder, other psych condition</td> <td><input type="checkbox"/> varicose veins</td> </tr> </table>	<input type="checkbox"/> arthritis	<input type="checkbox"/> back problems	<input type="checkbox"/> diabetes	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> blood clots	<input type="checkbox"/> insomnia	<input type="checkbox"/> broken/dislocated bones	<input type="checkbox"/> muscle strain/sprain	<input type="checkbox"/> bruise easily	<input type="checkbox"/> pregnancy	<input type="checkbox"/> cancer	<input type="checkbox"/> scoliosis	<input type="checkbox"/> chronic pain	<input type="checkbox"/> seizures	<input type="checkbox"/> constipation/ diarrhea	<input type="checkbox"/> whiplash	<input type="checkbox"/> auto-immune condition*	<input type="checkbox"/> circulatory problems	<input type="checkbox"/> hepatitis (A, B, C, or other)	<input type="checkbox"/> dizziness	<input type="checkbox"/> skin conditions	<input type="checkbox"/> heart condition	<input type="checkbox"/> stroke	<input type="checkbox"/> frequent headaches/migraines	<input type="checkbox"/> TMJ disorder	<input type="checkbox"/> diverticulitis	<input type="checkbox"/> depression, panic disorder, other psych condition	<input type="checkbox"/> varicose veins	<p>Please indicate areas where you are feeling or frequently have felt discomfort.</p> 
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Do you have or have you had any of the following within the last 24 hours:

- skin rash       cold/flu       open cuts/lesions       injury\bruises       severe pain
- consumed alcohol (if so, how much?\_\_\_\_\_)

Draping is used for your comfort and to protect your modesty. However, some people do not wish to use draping. Texas State Law requires written approval to forgo draping. If you want to use draping, please move to the next question. If you wish to forgo draping, please sign here indicating your approval: \_\_\_\_\_

Texas Laws also require your approval for therapeutic breast massage. Therapeutic breast massage is primarily used when there is discomfort, tightness or soreness in the chest, scar tissue from surgeries, discomfort or pain from engorgement due to lactation, or part of a posture treatment program. If you wish to include a therapeutic breast massage, please indicate your approval by signing here: \_\_\_\_\_

If you are unsure if you need (or want) a therapeutic breast massage, please ask your therapist.

I KNOW AND UNDERSTAND THE FOLLOWING:

1. I understand that I may stop the session at any time I feel the need.
2. I have informed the massage therapist of all my known conditions and medications and I will keep the massage therapist updated to any changes.
3. I understand that massage therapy is not a substitute for medical treatment or medications and that it is recommended that I concurrently work with my Primary Caregiver for any conditions that I may have.
4. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.
5. The therapist reserves the right to end session in the case of sexual innuendo or advances from client, and client has same right in instance of sexual advances or innuendo from therapist.

I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_