Client Intake Form

Name: ______________________ Date: ______________________

Address: ______________________

City: ______________________ State: __________ Zip: __________

Preferred Contact #: ______________________ Cell Phone #: ______________________

Email: ______________________ Date of Birth: ______________________

Occupation: ______________________

Referred by: ______________________ Phone #: ______________________

Physician: ______________________ Phone #: ______________________

Preferred Appointment Day and Time: ______________________

In case of emergency, please notify:

Name: ______________________ Phone #: ______________________

Relationship: ______________________

I agree that Harrington Massage Therapy may use one or more massage modalities in my session(s) such as, but not limited to: Neuromuscular, Lymphatic Drainage Therapy, Craniosacral, Visceral Manipulation. I understand that my entire body will be massaged with the exception of any contraindicated areas. I understand that breast massage will not be performed without written consent. I understand that draping will be used in my session. If I am uncomfortable for any reason I may terminate the massage. I understand that massage bodywork 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 of which I am aware. I further understand that the Therapist is 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 session(s) given should be construed as such. Because massage bodywork 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(s), and will be liable for payment of the scheduled appointment. I agree to pay in full for my session should I fail to give a 24 hour cancellation notice.

Client Signature: ______________________ Date: ______________________

Therapist Signature: ______________________ Date: ______________________

Consent to Bodywork of Minor:
By my signature below, I authorize the Therapist to administer Massage Bodywork or somatic therapy techniques to my child or dependent, as he/she deems necessary.

Signature of Parent or Guardian: ______________________

Date: ______________________

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What is your major complaint or condition you want to improve? ______________________________

____

When did you first notice major complaints and what brought it on? ______________________________

____

Does this condition interfere with work? ❑ Yes ❑ No Sleep? ❑ Yes ❑ No Daily Routine? ❑ Yes ❑ No

Please Explain: ____

____

What have you done to get relief? ____

____

Are you now under medical/therapeutic treatment? ❑ Yes ❑ No

If yes, for what condition? ____

____

What are your intentions or expectations for this visit? ____

____

List any medications (including aspirin) and nutritional supplements you are taking: ______________________

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Describe the exercise activities you do (include frequency): ______________________________________

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Have you ever had any bodywork (massage, acupuncture, chiropractic) before? ______________________

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Do you have currently or have had in the past, any of the following?

Accidents *(car, cycle, ski)*:	❑ Yes	❑ No	Headaches:	❑ Yes	❑ No
Allergies:	❑ Yes	❑ No	Hepatitis:	❑ Yes	❑ No
Baldder issues:	❑ Yes	❑ No	HIV/AIDS:	❑ Yes	❑ No
Bleeding:	❑ Yes	❑ No	Impetigo/warts:	❑ Yes	❑ No
Broken Bones:	❑ Yes	❑ No	IUD:	❑ Yes	❑ No
Cancer:	❑ Yes	❑ No	Joint replacements:	❑ Yes	❑ No
Chemical Sensitivities:	❑ Yes	❑ No	Pacemaker:	❑ Yes	❑ No
Constipation:	❑ Yes	❑ No	Pregnancy:	❑ Yes	❑ No
Contact lenses:	❑ Yes	❑ No	Rashes or cuts:	❑ Yes	❑ No
Contagious Disease:	❑ Yes	❑ No	Sciatica:	❑ Yes	❑ No
Edema/Swelling:	❑ Yes	❑ No	Stints/mesh:	❑ Yes	❑ No
Erectile dysfunction:	❑ Yes	❑ No	Surgeries:	❑ Yes	❑ No
Excessive Gas:	❑ Yes	❑ No	Tuberculosis:	❑ Yes	❑ No
Gerd/Indigestion:	❑ Yes	❑ No	Other:	❑ Yes	❑ No

If yes to any of the above, please explain (please include dates): ______________________________

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Because massage/bodywork 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 forget to do so. It is also understood that the services I will receive are strictly professional and not to be misconstrued as anything other than therapeutic.

Signature: ______________________________ Date: ______________________________

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