WellCare Medical Associates

Massage Therapy Intake Form

Today's Date ___________________________

Name ____

Phone (cell/text) _______________________ Phone (home) _______________________ Phone (work) ______________________

Address____

City ____ State _____________ Zip ________________

Email ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Date of Birth ________/_________/____________ Occupation ____

Emergency Contact __________________________________ Phone ____

In our efforts to promote massage and reach new clients, could you please tell us how you heard about us?

Referral: ☐ Family ☐ Friend Please specify: ____

Other: ☐ Website/online search ☐ Gift Certificate ☐ Drive by/sign ☐ Event

Have you had a professional massage before? Yes No

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

Do you have any allergies? Yes No

If yes, please explain ____

Do you have sensitive skin? Yes No

Do you wear contact lenses ( ) dentures ( ) a hearing aid ( ) ?

Do you sit or stand for long hours at a workstation, computer, or driving? 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? ____

Do you currently take any medications/vitamins/supplements? Yes No

If yes, please list ____

What type of pressure do you prefer?

Light Medium Deep

Are you currently under the care of a physician? Yes No

If yes, please explain ____

____

____

Right Left Left Right

O - pain or tenderness
S - joint or muscle stiffness
N - numbness or tingling
X - wounds

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

Please mark if you currently have (or have had in the past) any of the items below:

- ☐ Neck/back injuries
- ☐ Headaches, migraines
- ☐ Seasonal allergies
- ☐ Arthritis
- ☐ Cancer
- ☐ TMJ/jaw problems
- ☐ Abnormal skin condition
- ☐ Heart/circulation problems
- ☐ High/low blood pressure
- ☐ Major Accident
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Implants
- ☐ Pregnant. If yes due date: ________
- ☐ Fibromyalgia
- ☐ Numbness/shooting pains
- ☐ Sprains
- ☐ Recent injuries
- ☐ Fusions, pins or screws
- ☐ Diabetes

Please explain any conditions that you have marked above ____

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Do you have any other concerns you would like to discuss with the massage therapist? ______________________

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Draping is used during the session – only the area being worked on will be uncovered.
Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session.
Informed written consent must be provided by parent or legal guardian for any client under the age of 18.

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 session, I will 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 may have. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness. 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 also understand that the Massage Therapist reserves the right to refuse to perform massage on anyone he/she believes to have a condition for which massage is contraindicated.

My signature also indicates my consent to the WellCare Medical Associates Massage Therapy Policy.

WellCare Medical Associates requires 24 hour notice to reschedule massage appointments. Late cancellation or failure to arrive for your scheduled appointment could result in a $25 cancellation charge, as well as loss of any groupon or gift certificate. A late arrival may require ending the session at the scheduled time, resulting in a shorter treatment.

Signature of client ____Date____________________

Signature of Massage Therapist_____________________________________ Date__________________

Thank you for your business – Please enjoy your session!