stillwaters HEALING

116 Chestnut Street E
Stillwater, MN 55082

Client Intake Form- Therapeutic Massage

Name _____ Today's Date _____

Occupation _____ Telephone _____

Mailing Address_____

Email _____ Date of Birth_____

How did you hear about us? _____

The following information will be used to help plan safe and effective massage sessions. It will be kept confidential. Please answer to the best of your knowledge.

Have you had professional massage before? Yes No

How recently?

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

Do you have any particular goals for this massage session? Yes No

If yes, please explain

Are you currently under the care of a physician, or are you currently taking any medications, prescription or over-the-counter? Yes No

If yes, please explain/list medications

Please circle any condition below that applies to you:

Anxiety	Varicose veins	Depression	High or low blood pressure
Blood clots	Heart condition	Bruise easily	Circulatory issues
Artificial joint	Diabetes	Headaches/migraines	Numbness
Cancer	Surgery	Recent injury	Pregnancy
Osteoporosis	Epilepsy/seizures	Skin condition	Osteo or rheumatoid arthritis

Please explain any condition you circled above:

Is there anything else about your health history that you think would be useful for your massage therapist to know?

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Consent and Waiver

If I experience any pain or discomfort during this session, I will immediately inform the practitioner 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 or other qualified medical specialist for any mental or physical ailment of which I am aware.

I understand that massage practitioners 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

Understanding all of this, I give my consent to receive care.

Client signature _____ Date_____

(If client is a minor child):

Parent/guardian signature _____ Date_____