

# Massage Therapy Intake Form

To be updated annually. Please alert therapist of any health changes at time of massage.

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ Home Telephone: \_\_\_\_\_

\_\_\_\_\_  
Business Telephone: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Occupation: \_\_\_\_\_

Referred by: \_\_\_\_\_

In case of an emergency, notify: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you ever had a professional massage? Yes No

What is your primary reason for massage appointment? \_\_\_\_\_

Have you been under a doctor's care in the last 12 months? (If yes, please explain)

Does the massage therapist have permission to contact your physician if necessary? Yes No

Physician Name and Phone Number \_\_\_\_\_

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**Please mark (X) for all conditions that apply now. Put a (P) for past conditions, and (F) for family history of illness.**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> headaches, migraines                | <input type="checkbox"/> chronic pain            | <input type="checkbox"/> fatigue                     |
| <input type="checkbox"/> vision problems, contact lenses     | <input type="checkbox"/> muscle or joint pain    | <input type="checkbox"/> tension, stress             |
| <input type="checkbox"/> hearing problems, deafness          | <input type="checkbox"/> muscle, bone injuries   | <input type="checkbox"/> depression                  |
| <input type="checkbox"/> Injuries to face or head            | <input type="checkbox"/> numbness or tingling    | <input type="checkbox"/> sleep difficulties          |
| <input type="checkbox"/> sinus problems                      | <input type="checkbox"/> sprains, strains        | <input type="checkbox"/> allergies, sensitivities    |
| <input type="checkbox"/> dental bridges, braces              | <input type="checkbox"/> arthritis, tendonitis   | <input type="checkbox"/> rashes, athletes foot       |
| <input type="checkbox"/> jaw pain, TMJ problems              | <input type="checkbox"/> cancer, tumors          | <input type="checkbox"/> infectious diseases         |
| <input type="checkbox"/> asthma or lung conditions           | <input type="checkbox"/> spinal column disorders | <input type="checkbox"/> blood clots                 |
| <input type="checkbox"/> constipation, diarrhea              | <input type="checkbox"/> diabetes                | <input type="checkbox"/> varicose veins              |
| <input type="checkbox"/> hernia                              | <input type="checkbox"/> pregnancy               | <input type="checkbox"/> high/low blood pressure     |
| <input type="checkbox"/> abdominal or digestive problems     | <input type="checkbox"/> birth control, IUD      | <input type="checkbox"/> heart, circulatory problems |
| <input type="checkbox"/> other medical conditions not listed | <input type="checkbox"/> Alzheimer / dementia    | <input type="checkbox"/> hepatitis B or C            |

Explain any areas noted above:

Current medications, including aspirin, ibuprofen, herbs, supplements, etc.:

Surgeries: \_\_\_\_\_

Accidents: \_\_\_\_\_

**Please Read and Sign the Informed Consent and the Appointment Agreement on the other side.**

Name: \_\_\_\_\_  
(please print)

**Informed Consent:**

I have completed the Confidential Client History Form to the best of my knowledge. I agree to keep the massage therapist updated on any changes in my health.

I understand that close contact with people increases the risk of infection from contagious diseases. I acknowledge that I am aware of the risks involved and give consent to receive massage services from Dexter Wellness Center. I understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for a highly contagious disease. My contact details will only be shared as relevant for contact tracing and only for appropriate follow-up by the health department.

I understand that massage services are designed as a health aid which is not intended to replace the services of a physician, physical therapist, chiropractor or other licensed medical provider nor does it constitute a doctor-patient relationship. I am aware that the massage therapist does not diagnose illness or disease.

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. If I experience any pain or discomfort during the session, I will immediately inform the massage therapist so the treatment can be adjusted. I understand that I have the right to ask the therapist to terminate or modify the treatment at any time, regardless of reason.

If I am utilizing other areas of the Wellness Center during my massage visit, I agree to the waiver and release guidelines followed by guests of the wellness center as stated here:

You acknowledge that your attendance at or use of Dexter Wellness Center's (DWC) Facility, including without limitation your participation in any of DWC's programs or activities and your use of DWC's equipment and facilities, and any transportation which may be provided by DWC, could cause injury, which may result from or arise out of your attendance at or the use of DWC's Facility or its equipment, activities, or transportation: and you agree, on behalf of yourself and your heirs, executors, administrators, and assigns, to fully and forever waive, indemnify, hold harmless, release and discharge DWC, its affiliates and all of their respective officers, trustees, employees, agents, successors, and assigns, and each of them (collectively, the "Releases"), from any and all claims, damages, demands, rights of action or causes of action, present or future, known or unknown, anticipated or unanticipated, resulting from or arising out of your attendance at or use of DWC's Facility, or its equipment, activities or transportation. Further, you hereby agree or waive any and all such claims, damages, demands, rights or action or causes of action. In addition, you hereby agree to release and forever discharge the Releases from any and all liability for any loss or theft, or damage to personal property. You acknowledge that you have carefully read this waiver and Release and fully understand that it is a waiver and release of any and all liability.  
I also agree to follow the same etiquette guidelines set forth for our members (copy of member handbook available upon request)

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Staff Initials: \_\_\_\_\_  
(or legal guardian if under 18 years of age)

**Guidelines for MINORS (under 18 years old) scheduling and receiving Massage.**

- A legal guardian will need to sign the Informed Consent and Appointment Agreement.
- The guardian must be in the massage room during the massage for anyone **14 years old and younger**.
- If the massage therapist, guardian and client agree, the guardian does not have to be in the room for 15, 16 or 17 year olds.

**Appointment Agreement:**

I agree to arrive 15 minutes before scheduled appointment to allow time to pay for and prepare for the massage. The massage will begin at the scheduled appointment time, ensuring that you receive the full benefit of the length of massage you requested.

If I am unable to keep the scheduled massage appointment, I must notify the Dexter Wellness Center of the cancellation 24 hours in advance of the scheduled appointment. If I fail to notify the Center within 24 hours in advance, a \$20 fee may be charged for my missed appointment.

I understand that the massage sessions and packages expire one year from date of purchase, may only be used at the center in which they are purchased, and are non-refundable.

**Recurring Appointments:**

While staff will assist with booking my "standing appointment" times, it is ultimately my responsibility to make sure my appointments are booked into upcoming months.

I understand and agree to the above conditions.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Staff Initials: \_\_\_\_\_  
(or legal guardian if under 18 years of age)