WellQuest Massage
Adva Goldberg L.M.T.
443.570.4143

Client Intake Form- Therapeutic Massage

Personal Information:

Name: ________________________ Phone (Home):______________ Phone (Cell)________________

Address:____

City/State/Zip____

E-Mail:______________________ Date of Birth: ____/____/_____Occupation:__________________

Emergency Contact____ Phone:__________________

How did you hear about us?____

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

Date of initial visit: ________________________

1. Have you had a professional massage before? Yes No
   If yes, how often do you receive massage therapy? __________________________
2. Do you have any difficulty lying on your front, back, or side? Yes No
   If yes, please explain ____
3. Do you have any allergies to oils, lotions, or ointments? Yes No
   If yes, please explain____
4. Do you have sensitive skin? Yes No
5. Are you wearing **Contact lenses** Y/N **Dentures** Y/N **Hearing aid(s)** Y/N
6. Do you sit for long hours at a workstation, computer or drive for long hours? Yes No
   If yes, please explain____
7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
   If yes, please explain____
8. Do you experience stress in your work, family, or other aspect of your life? Yes No
   If yes, please explain____
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No
   If yes, please explain____
10. Do you have any particular goals in mind for this massage session? Yes No
    If yes, please explain____

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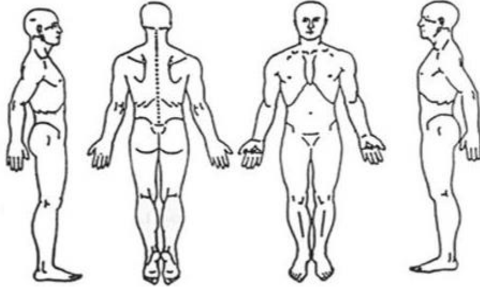

Circle any specific areas you would like the massage therapist to concentrate on during the session

Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

1. Are you currently under medical supervision? Yes No
   If yes, please explain____

2. Do you see a chiropractor? Yes No If yes, how often______________________________

3. Are you currently taking any medication? Yes No
   If yes, please explain____

4. Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wound
( ) easy bruising
( ) recent accident or injury
( ) recent surgery
( ) recent fracture
( ) artificial joint
( ) sprains/ strains
( ) current fever
( ) swollen glands
( ) allergies/ sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis

( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder/rheumatoid arthritis
( ) osteoarthritis/tendonitis
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) Fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) pregnancy If yes, how many months? ____

Please explain any condition that you have marked above:____
____

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? ____
____

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Draping will be used during the session- only the area 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 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 immediately inform the therapist so the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be constructed 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 aliment that I am aware of. I understand that massage therapist 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 can be constructed 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 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.

___ If you do not cancel 24 hours prior to appointment time, you will be charged $45 for the appointment unless it is an emergency.

Signature of client ____ Date______________________

Signature of Massage therapist_______________________________ Date______________________