BodyBloom™ Massage Studio
Client Health Intake Form for Therapeutic Massage

Personal Information

Date of Initial Visit: _____

Name: _____ Date of Birth:_____

Preferred Phone #_____ Texting ok? Yes/No

Address_____

Email_____ Occupation_____

Emergency Contact_____ Phone: _____

Please answer the following questions to help plan safe and effective massage sessions.

Important note: Massage therapy is contraindicated during the first trimester of pregnancy.

Are you or is there a chance that you may be pregnant? Yes/No

1. Have you had a professional massage before? Yes/No If yes, how often? _____
2. What level of pressure do you prefer? Light [ ] Medium [ ] Firm [ ] Deep [ ] Unsure [ ]
3. Do you have any difficulty or discomfort lying on your front, back, or side? Yes/No

   If yes, please explain _____
3. Do you have sensitive skin or any allergies to oils, creams, or ointments? Yes/No

   If yes, please explain _____

   Your preference: Warm organic coconut oil [ ] Unscented cream [ ] Unscented oil [ ]
4. Do you sit for long hours or perform repetitive movements at work, sports, or hobby? Yes/No

   If yes, please describe _____
5. List any surgeries or significant injuries during the past 5 years:_____

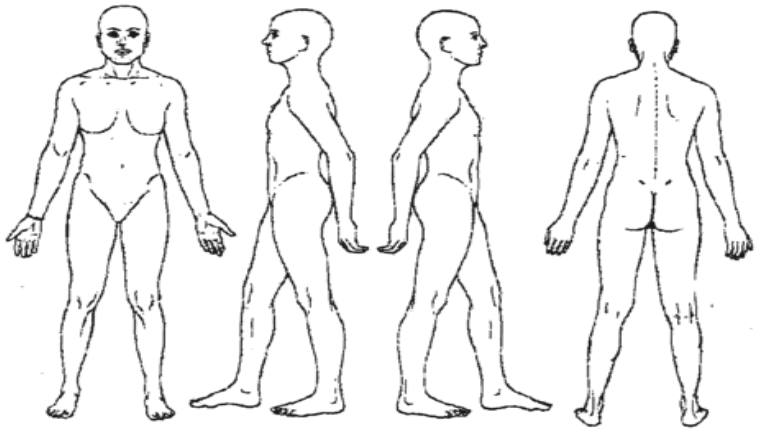
_____

6. List any specific areas where you experience tension, stiffness, pain or discomfort.

_____

7. What are your massage treatment goals? _____

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



Medical History

8. Are you currently under medical supervision? Yes/No

If yes please explain _____

9. Do you see a chiropractor? Yes/No If yes, how often? _____

10. Are you currently taking any medication? Yes/No

If yes, please list _____

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

[ ] contagious skin condition	[ ] open sores or wounds	[ ] artificial joint
[ ] easy bruising	[ ] recent accident or injury	[ ] recent fracture
[ ] recent surgery	[ ] swollen glands	[ ] allergies/sensitivity
[ ] sprains/strains	[ ] current fever	[ ] heart condition
[ ] high or low blood pressure	[ ] circulatory disorder	[ ] atherosclerosis
[ ] varicose veins	[ ] deep vein thrombosis/blood clot	[ ] epilepsy
[ ] phlebitis	[ ] osteoporosis	[ ] decreased sensation
[ ] headaches/migraines	[ ] carpal tunnel syndrome	[ ] cancer
[ ] diabetes	[ ] Fibromyalgia	[ ] back/neck problems
[ ] TMJ	[ ] joint disorder/arthritis/tendonitis	[ ] tennis elbow

Please explain any condition that you have marked above:

_____

_____

_____

12. 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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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 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 am aware of. I understand that massage therapists 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 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 also that a parent or legal guardian must accompany any client under the age of 17 during the entire session.

Client Signature_____ **Date:**_____

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