Stacy Pickhardt, LMT

MA# 55998 MM# 25147

Client Intake Form
Therapeutic & Relaxation Massage

Personal Information

Name:_____ Today's Date:_____

Phone (*Home*): ( ) - Phone (*Cell*) ( ) -

DOB:

Address: City/State/Zip

Email:

Occupation:

Emergency Contact:

Name:

Phone: ( ) -

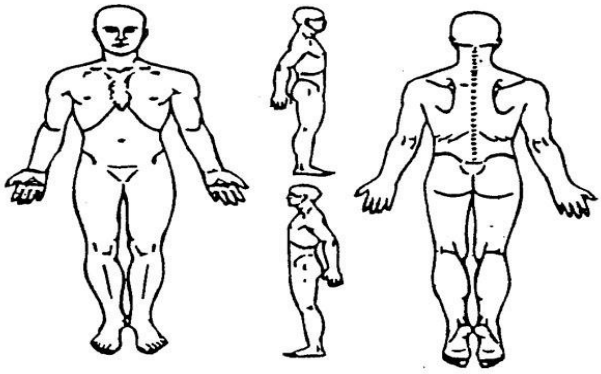
The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge

1.Have you had a professional massage before? (Circle) Yes or No
***If yes, how often do you receive massage therapy?

2. Do you have any allergies to oils, lotions, or ointments? (Circle) Yes or No
***If yes, please explain

3. Is there a particular area of the body where you are currently experiencing tension, stiffness, pain or other discomfort? (Circle) Yes or No
***If yes, please identify

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



Describe any chronic pain/tension:

What makes it better?

What makes it worse?

Please mark any of the following that you now have, or have had in the past (indicate side of body where necessary):

MUSCULOSKELETAL
Bone or joint disease_____
Tendonitis/bursitis m Arthritis/gout_____
Sprains/strains ____
Low back/hip/leg pain____
Neck/shoulder/arm pain____
Spasms/cramps____
Jaw pain/TMJ____
Lupus m Osteoporosis____
Other: _____

NERVOUS SYSTEM
Shingles____
Numbness/tingling____
Pinched Nerve____
Other: _____

DIGESTIVE
Constipation____
Gas/bloating____
Irritable bowel syndrome____
Ulcers____
Other: _____

SKIN
Allergies
Rashes
Athlete's foot
Herpes/cold sores
Other: _____

CIRCULATORY
Heart condition/Pacemaker____
Phlebitis/varicose veins____
High/Low blood pressure____
Lymphedema____
Blood Clots____
Other: _____

OTHER
Cancer/tumors____
Alcohol/Caffeine/Tobacco use____
Fibromyalgia____
DVT Deep Vein Thrombosis____
Chronic fatigue____
Chronic pain____
Sleep disorders____
Migraines/headaches____
Anxiety/stress syndrome____

PLEASE CHECK ALL THAT APPLY TODAY

Pregnancy: stage_____

Infection_____
Inflammation/swelling_____
Fever_____

Flu_____
Cold_____
Communicable diseases? *(i.e. Contagious Skin Conditions)*_____

_____

Additional Client Remarks/Comments:

****I understand that a massage therapist does not diagnose disease, illness, or prescribe any treatment or drugs, nor do they provide spinal manipulation. I understand that *draping will be used at all times* and that breast massage will not be administered on female clients. I understand that if I become uncomfortable for any reason that I may ask the Therapist to end the massage session, and they will end the session. *I understand that the massage Therapist may end the session for any inappropriate behavior*. I have stated all of the conditions that I am aware of, and this information is true and accurate. I will inform the health care provider of any changes in my status.****

Client Signature:

_____Date:_____

(If Minor)
Parent Signature:

_____Date:_____