GOOD MEDICINE MASSAGE LLC

Therapeutic Massage for Pain Management • Stress Relief • Relaxation

Jennifer Wayland
303.725.7242

Health History Intake Form

Name _____ Date of Initial Visit _____

Address _____ City, State, Zip _____

Phone _____ Emergency contact/Phone _____

Date of Birth _____ Age _____ Occupation _____

Name of Physician _____ Phone _____

Referred By _____

What is your reason for seeking massage therapy? (relaxation, resolve pain/injury issues, etc.)

Have you ever received professional massage? **Yes** **No** If so, how recently?_____

Check if you wear ( ) contact lenses ( ) dentures ( ) hearing aid ( ) other (specify)

Do you have any allergies to oils, lotions, ointments, liniments, etc. put on your skin? **Yes** **No**
If Yes, Please Describe

Do you have tension, soreness or other discomfort in any specific area (numbness, etc)? **Yes** **No**
If Yes, Please Describe

Do you perform any repetitive movement in your work, sports or hobbies, or sit for long hours at a workstation or driving? **Yes** **No**
If Yes, Please Describe

Do you have any medical condition(s) or are you taking any medications? **Yes** **No**
If Yes, Please Describe

Do you have high blood pressure? **Yes** **No**
If Yes, Please List Medications You Are Taking

Have you been in an accident or suffered any injuries in the past 2 years? **Yes** **No**
If Yes, Please Describe

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Have you had any surgery in the past 5 years? **Yes** **No**
If Yes, Please Describe

Please describe any other major surgeries, accidents or illness in your history.

_____

_____

For Women: Are you pregnant? **Yes** **No**

If Yes, How Far Along _____

Please check any of the following that apply to your current health:

____ arthritis/joint issue
____ heart condition
____ bruise easily
____ blood clots
____ osteoporosis
____ circulatory condition
____ lymphatic condition
____ cancer
____ varicose veins
____ frequent headaches
____ any infectious or contagious disease
____ diabetes
____ epilepsy/seizures

Comments/Details (If Applicable)

_____

Has a physician/health care provider recommended massage for any of the conditions above? **Yes** **No**
If Yes, Please Describe

List and prioritize your current symptoms/issues (stress, pain/stiffness, numbness/tingling, etc.)

_____

Do these symptoms interfere with your daily living/activities? (sleep, exercise, work, etc)

_____

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Do you experience stress in your work, family or other aspect of your life? **Yes** **No**

How would you describe your stress **Low** **Medium** **High** **Very High**

Please describe any exercise/stress reduction activities you practice regularly.

Please describe anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you.

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage therapy may be contradicted. A referral from your primary care provider may be required prior to service being provided.

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I also understand that any illicit, inappropriate or suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my massage therapist of any changes in my health status.

Signature _____ Date _____

Consent to treatment for a minor

By my signature below, I hereby authorize _____ to administer massage therapy to my child or dependent as they deem necessary.

Signature _____ Date _____

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Office Policies

Although it is rare to have to exercise the rules and regulations, there are a few. This helps to keep the relationship between therapist and client as professional and therapeutic as possible.

Sickness

Massage is never appropriate care for any infectious or contagious illness.
Please cancel your appointment as soon as you are aware of any infectious or contagious condition. There will not be any cancellation fee for health-related cancellations.

Cancellation

If you should need to cancel or reschedule your appointment, a 48 hours notice is preferred. A 24 hour notice is required in order to avoid a $40 cancellation fee. Payment is due before your next appointment.

****Cancellation fee may be waived if the reason is health related, or due to unsafe driving conditions.
***** A NO-CALL, NO-SHOW WILL BE CHARGED THE FULL AMOUNT OF THE SESSION. PAYMENT WILL BE DUE BEFORE YOUR NEXT SESSION.**
***** PLEASE UNDERSTAND THIS POLICY IS IMPLEMENTED TO HELP COVER THE COST OF ANY OTHER PAYING CLIENTS THAT MAY HAVE BEEN TURNED AWAY WHEN AN APPOINTMENT HAD BEEN HELD FOR YOU.**

Tardiness

Appointment times are as scheduled and cannot be extended beyond the stated time to accommodate late arrivals. Please be on time to your appointment.

Your signature below signifies acceptance of these policies.

Client Name (printed) _____ Date _____

Signature _____