Emerald's Mobile Therapeutic Massages

Client Intake Form

Name _____

Date of Birth ____ / ____ / ____

Address _____ Primary Contact # _____

City _____ Zip _____ email _____

Emergency Contact _____

Primary Contact #_____ Secondary Contact # _____

Relationship _____

When was the last time you had a professional massage? _____

What is your preference of pressure? _____

Are you allergic to any aromatherapy scents or essential oils? _____

Are you currently pregnant? _____ If yes, state your expected due date _____

Are you taking any medications? _____ If yes, please state below:

_____

_____

_____

Please take a moment to carefully read and mark any of the conditions listed below. If you have specific medical conditions or symptoms, your massage may be contraindicated. A referral from your primary Dr. may possibly be required.

Allergies ___ Arthritis __ Asthma __ Back/Neck Pain __ Bruise Easily __ Cancer __ Cardiac/Circulatory Issues __ Diabetes __ Eczema __ Epileptic Seizures __ Fibromyalgia __ Frequent Chronic Stress __ Headaches __ Herpes __ joint Pain/Swelling __ Lupus __ Migraines __ Nerve Conditions __ Neuropathy __ Numbness __ Osteoarthritis __ Post Partum Depression __ Psoriasis __ Recent Injuries __ Recent Surgeries __ Stabbing Pain __ Stroke __ Other conditions not listed __

In only a few words, please give a brief detail about your current conditions or any conditions not listed below:

_____

_____

_____

_____

Terms and Conditions:

I understand the massage I will receive is provided for the basic purpose of relief from stress and muscular tension. If I experience any pain or discomfort during session, I will immediately inform the practitioner so that the pressure may be adjusted to my comfort. I further understand that massage should not be considered a substitute for medical examination, diagnosis, or treatment and that I should see a health specialist or physician for any medical ailment of which I am aware. I understand that the practitioner is not qualified to perform any skeletal / spinal adjustments, diagnosis, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be considered as such. Because massage shouldn't be performed under certain medical conditions, I affirm that I have stated all my known medical conditions to the above profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances by me will result in immediate termination of the session.

Client Signature _____ Date ____ / ____ / _____

Client S.O.A.P. Chart -- office use only!

Subjective:

Objective:

Assessment:

Progression: