New Body THERAPEUTICS

Client Intake Form

Name: _____ DOB (MM/DD/YYYY): _____/_____/_____

□ Male □ Female Home Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____

City/State/Zip: _____

Occupation:_____ E-mail: _____

How did you hear about us?_____ Referred by: _____

Emergency Contact: _____ Phone: (_____) _____

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/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever had a professional massage or bodywork session? □ Yes □ No How recently?_____

What are your massage or bodywork goals?_____

What kind of pressure do you prefer? □ Light □ Moderate □ Firm □ Deep Tissue (extra fee may apply)

Please check ALL boxes that apply to you and provide a clear explanation when necessary.

Yes	*No*	
□	□	Frequently suffer from stress
□	□	Do you have diabetes? If yes, what meds? _____
□	□	Frequently suffer from headaches? _____
□	□	Are you pregnant? If yes, how many weeks? _____
□	□	Do you have high blood pressure? If yes, what meds? _____
□	□	Do you suffer from epilepsy or seizures?
□	□	Do you suffer from joint swelling? If yes, where? _____
□	□	Do you have varicose veins? If yes, where? _____
□	□	Do you have osteoporosis?
□	□	Do you have allergies? If yes, to what? _____
□	□	Do you bruise easily?
□	□	Have you broken any bones in the last 2 years? If yes, which? _____
□	□	Have you had any recent injuries or surgeries we should know about? If yes, what? _____
□	□	Do you have any common or plantar warts? If yes, where? _____
□	□	Do you have tension or soreness? If yes, where?_____
□	□	Do you have cardiac or circulatory problems?
□	□	Are you sensitive to touch or pressure? If yes, where?_____
□	□	Other medical conditions or medication?_____

I understand that the massage I receive is provided for the basic purpose of relaxation. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure may be adjusted to my comfort. I understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that massage therapists are not qualified to perform spinal adjustments, diagnose, prescribe, or treat any physical or mental illness, and 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 that I will be charged half of the service cost if I should have to cancel the same day as my appointment. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of scheduled appointment.

Client signature_____ Date:_____

Therapist Signature_____ Date:_____