ELEVATE

MASSAGE THERAPY

Name ______________________________ Email ______________________________

Phone (Cell) ______________________________ Phone (Home) ______________________________

Address ____

City ______________________________ State __________ Zip ____________________

Date of Birth ______________________________ Occupation ______________________________

Emergency Contact ______________________________ 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.

Date of Initial Visit ____

1. Have you had a professional massage before? Yes ☐ No ☐
   If yes, how often do you receive massage therapy? ______________________________
2. Do you have any difficulty lying on your front, back, or side? Yes ☐ No ☐
   If yes, please explain ______________________________
3. Do you have any allergies to oils, lotions, or ointments? Yes ☐ No ☐
   If yes, please explain ______________________________
4. Do you have sensitive skin? Yes ☐ No ☐
5. Do you sit for long hours at a workstation, computer, or driving? Yes ☐ No ☐
   If yes, please describe ______________________________
6. Do you perform any repetitive movement in your work, sports, or hobby? Yes ☐ No ☐
   If yes, please describe ______________________________
7. Do you experience stress in your work, family, or other aspect of your life? Yes ☐ No ☐
   If yes, how do you think it has affected your health?
   Muscle tension ☐ anxiety ☐ insomnia ☐ irritability ☐ other ______________________________
8. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?
   Yes ☐ No ☐
   If yes, please identify ______________________________
9. Are there any areas you would like me to avoid? ______________________________
10. Do you have any particular goals in mind for this massage session? Yes ☐ No ☐
    If yes, please explain ______________________________

11. Place a mark on the continuum below to show your desired mix of therapeutic and relaxation
Therapeutic____Relaxing

12. Please list any additional comments regarding your session that will enhance your experience today:
    ____
    ____

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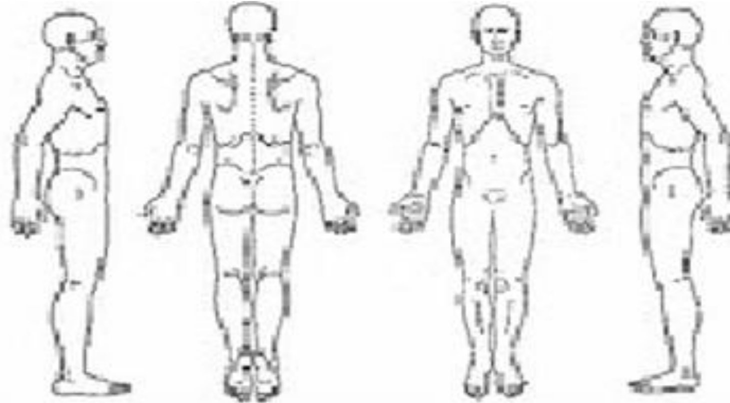

Circle any specific areas you would like the massage therapist to concentrate on during the session

Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

13. Are you currently under medical supervision? Yes ☐ No ☐
    If yes, please explain ____
14. Do you see a chiropractor? Yes ☐ No ☐ If yes, how often? ______________________________________
15. Are you currently taking any medication? Yes ☐ No ☐
    If yes, please list ____
16. Please check any condition listed below that applies to you:

☐ contagious skin condition	☐ phlebitis
☐ open sores or wounds	☐ deep vein thrombosis/blood clots
☐ easy bruising	☐ joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
☐ recent accident of injury	☐ osteoporosis
☐ recent surgery	☐ epilepsy
☐ artificial joint	☐ headaches/migraines
☐ sprains/strains	☐ cancer
☐ current fever	☐ diabetes
☐ swollen glands	☐ decreased sensation
☐ allergies/sensitivity	☐ back/neck problems
☐ heart condition	☐ Fibromyalgia
☐ high or low blood pressure	☐ TMJ
☐ circulatory disorder	☐ carpal tunnel syndrome
☐ varicose veins	☐ tennis elbow
☐ atherosclerosis	☐ pregnancy if yes, how many months? ____________________

    Please explain any condition that you have marked above ______________________________________
    ____
17. 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? ______________________________________
    ____

Draping will be used during the session – only the area being worked on will be uncovered.

Informed written consent must be provided by parent or legal guardian for any client under the age 17.

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Treatment Consent Form

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 massage 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 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 that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the License Massage Therapy reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

Signature of client ____ Date ______________________

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Minor Informed Consent

I, ____, herby give permission (and until further notice) to Elevate Massage Therapy to provide my minor child, __________________________________, under my guardianship with therapeutic massage services deemed appropriate to treat presenting conditions/injuries. I understand that I am financially responsible for the minor, and that all statements contained in this consent apply equally to myself and to the minor.

Signed ____ Date _________________________
Parent/Guardian

My child has my permission to appear for treatment without me present and I further understand that I must make the appointments.

Signed ____ Date _____________________
Parent/Guardian

E L E V A T E

MASSAGE THERAPY

Prenatal Intake and Consent Form

Name: _______________________________________ Date: _________________________

Address:____

Email address:____

Best number to reach you at: ___________________________ May we leave a message here? Yes____ No____

Your Date of Birth: ____________________________

What trimester are you in? _________ Expected Due Date: _______________

Prenatal Care Provider/Doctor: ____

Provider's Phone number: ____

May we have permission to contact doctor if necessary? ____________________________

Have you had prenatal massage before? Yes ___ No ______

Is your pregnancy considered to be high risk? Yes_______ No________

If so, do you have a doctor's release? __________

If yes, what are the reasons?

____

____

Have you had any complications or problems in this pregnancy? (Please explain)

____

____

____

I have completed this intake and consent form to the best of my knowledge. I understand that massage therapy is a health aid and does not take the place of a physicians' care. Any information exchanged during a massage session is confidential and is only used to provide the best massage care. If I am having or develop any complications I will discuss with my massage therapist. I hereby voluntarily release Elevate Massage Therapy, Elevate Fitness & Rehab and it's massage therapists of from any liability should my condition be aggravated at any time. By signing below, I agree that I have read the information above and have decided to receive a prenatal massage at my own risk.

Signature__________________________________ Today's Date: ____________________________

Print name: ____