Lighthouse Massage - *Client Intake form*

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www.LighthouseMassage.org

NAME: _____ DATE: _____

ADDRESS: _____ STATE/ZIP:_____

BIRTHDATE: _____ AGE: _____ HOME/CELLPHONE: _____

OCCUPATION: _____

REFERRED BY: _____

1. Are you currently under the care of a health practitioner? ☐Yes ☐No
If yes, please explain your health concerns: _____

_____

Health Practitioner's Name: _____ Phone: _____

2. Please check if you have any of the following conditions:

____ wearing contact lenses
____ recent injury
____ diabetes
____ kidney problems
____ high blood pressure
____ contagious skin disorder(s)
____ other circulatory problems_____
____ pregnancy
____ recent illness
____ phlebitis
____ Joint problems
____ cancer or undiagnosed growth
____ chronic illness/health problems
____ varicose veins
____ recent surgery
____ blood clots
____ chronic pain

3. Are you taking any medications? ☐Yes ☐No
If yes please indicate what kind(s): _____

_____

4. What are the main sources of stress in your life? _____
5. Where in the body do you feel the effects of stress? _____
6. What do you do for relaxation and/or exercise? _____
7. Prioritize the ares of your body that you prefer to be massaged: _____
8. Please check the areas of your body you give permission to receive massage:

____ head ____ face ____ neck ____ chest ____ arms ____ hands ____ abdomen
____ feet ____ legs ____ hips/buttocks ____ back upper/lower
____ I give permission for all of these areas to be massaged if needed

It is my choice to receive massage therapy. I realize that the treatment is being given to assist in my well-being, both body and mind. This includes stress reduction, relief from muscular tension or spasm of pain, injury rehabilitation, or increasing circulation/energy flow. I agree to communicate with my therapist at any time if I feel like my well-being is compromised. I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I have stated all medial conditions that I am aware of and will update the massage therapist of any changes in my health status.

SIGNATURE: _____ DATE: _____