Lighthouse Massage - *Client Intake form*

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

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 areas 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, muscle spasm, pain, injury rehabilitation, or increasing circulation/energy flow. I understand these benefits and potential risks to receiving massage. 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 medical conditions that I am aware of and will update the massage therapist of any changes in my health status. I understand the information above is confidential and I have had the opportunity to view the HIPAA policy.

SIGNATURE: _____ DATE: _____