Myssage by vikki

860 Ralph Hall Pkwy, Ste 44
Rockwall, Tx 75032

P: (214) 994-8843
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Massage Guest Intake Form

Personal Information:

Name: _____ Phone: (_____)_____-_____ Type: ☐ H ☐ W ☐ C

(If cell include carrier for text confirmations)

Address: _____

City/State/Zip: _____

Email: _____ Date of Birth: _____

Occupation: _____ How were you referred to us: _____

Emergency Contact Name & Phone: _____ (_____)_____-_____

What is your preferred method of contact for follow-up within 1 week after your visit? Please include cell phone & carrier for texting, email address preferred, or phone number where messages may be left:

_____

Medical History:

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

1. Are you currently under medical supervision? Yes☐ No☐
   If yes, please explain: _____

2. Do you see a chiropractor? Yes☐ No☐ If yes, how often? _____

3. Are you currently taking any medication? Yes☐ No☐
   If yes, please list: _____

4. What type of massage are you here for today? (Note: a relaxation massage will NOT include working out "knots" or any other form of corrective bodywork)

○ *Relax* ○ *Pediatric* ○ *Pre-natal* ○ *Bodywork* ○ *Combination* ○ *Sports* ○ *Chair* ○ *Reflexology* ○ *Essential Oil* ○ *Unsure*

Would you like gluteal work done? ☐ Yes ☐ No Would you like abdominal work done? ☐ Yes ☐ No

5. Please check & circle any condition(s) listed below that a ***doctor* has diagnosed you** with:

(☐) Easy bruising (☐) Atherosclerosis

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- ☐ Recent accident or injury
- ☐ Recent fracture
- ☐ Recent surgery
- ☐ Artificial joint
- ☐ Sprains
- ☐ Strains
- ☐ Allergies / Sensitivity (list below)
- ☐ Heart condition
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Circulatory disorder
- ☐ Varicose veins
- ☐ Phlebitis
- ☐ Lymphadema
- ☐ Deep vein thrombosis / Blood clots (circle)
- ☐ Joint disorder / Rheumatoid arthritis / Osteoarthritis / Tendonitis (circle)
- ☐ Osteoporosis / Lordosis / Kyphosis / Scoliosis (circle)
- ☐ Epilepsy
- ☐ Headaches / Migraines (circle)
- ☐ Cancer _____ (type)
- ☐ Diabetes / Hypoglycemia (circle)
- ☐ Decreased sensation / Neuropathy
- ☐ Back / Neck problems (circle)
- ☐ Fibromyalgia
- ☐ TMJ
- ☐ Carpal tunnel syndrome
- ☐ Tennis elbow
- ☐ Skin disorder / Explain: _____
- ☐ Pregnancy / If yes, how many weeks _____ / Due date: ___/___/_____

Please explain any condition that you have marked previously:

_____

_____

ALLERGIES/SENSITIVITIES—Please list

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. 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?

_____

_____

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I certify the above is true, correct & complete to the best of my knowledge & accept responsibility in making sure any changes to the above information are changed as soon as they occur.

_____ I, _____, the Legal Guardian or Natural Parent of the above named minor, do hereby acknowledge I will not accompany said minor into the session room (initials indicate agreement).

Agreement & Informed Consent to Treatment

Client has been properly informed & agrees to the treatment plan outlined during the consultation & may revoke this agreement at any time by calling an end to the session or by discontinuing visits. We agree to adhere to the specified boundaries. If for some reason the Client cannot adhere to the boundaries, the Therapist will discuss a course of action that may result in a right to refuse treatment of the Client.

Signature of Guest: _____ Date: ___/___/_____
(or Legal Guardian)

Printed Name of Guest: _____
(or Legal Guardian)

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