East Carolina Massage, LLC
210 S Washington Street
Greenville, NC 27858
252-413-0021

Client Intake Form

Name _____ email _____

Phone ( ) _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Occupation _____

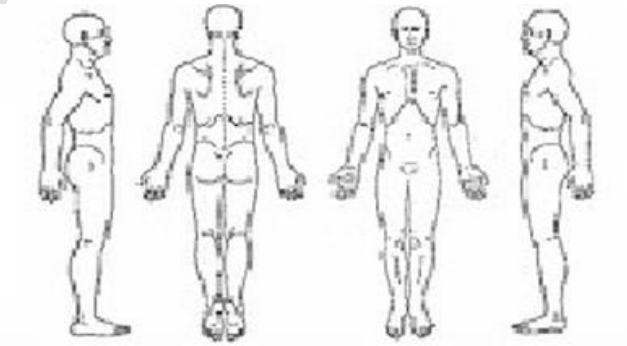
Emergency Contact _____ Phone _____

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, ointments, food (tree nuts) or medications**?
   Yes ☐ No ☐ If yes, please explain _____
4. Do you have sensitive skin? Yes ☐ No ☐
5. Are you wearing contact lenses ☐ dentures ☐ a hearing aid ☐?
6. Do you sit for long hours at a workstation, computer, or driving? Yes ☐ No ☐
   If yes, please describe _____
7. Do you perform any repetitive movement in your work, sports, or hobby? Yes ☐ No ☐
   If yes, please describe _____
8. 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 _____
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes ☐ No ☐ If yes, please identify_____
10. Do you have any particular goals in mind for this massage session? Yes ☐ No ☐
    If yes, please explain _____

Please 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.

11. Are you currently under medical supervision? Yes ☐ No ☐
    If yes, please explain _____
12. Do you see a chiropractor? Yes ☐ No ☐ If yes, how often?
    _____
13. Are you currently taking any medication? Yes ☐ No ☐
    If yes, please list _____
14. 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
☐ recent accident or injury	☐ arthritis/osteoarthritis/tendonitis
☐ osteoporosis	☐ pregnancy if yes, how many weeks?_____
☐ 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	

    Please explain any condition that you have marked above _____
    _____
15. 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 age 17.

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 _____

Signature of Massage Therapist _____ Date _____