

# DREAMSCAPES MASSAGE

## Client Intake Form

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation \_\_\_\_\_ Referred by \_\_\_\_\_

Have you ever experienced a professional massage/bodywork session? \_\_\_\_\_

What are your massage expectations/goals? \_\_\_\_\_

What kind of pressure do you prefer? Light Medium Firm Deep Tissue

Do you have any limited range of motion? Explain \_\_\_\_\_

Is there any area you prefer not worked? (abdomen, glutes, feet, etc.) \_\_\_\_\_

Allergies (aromas/essential oils/shellfish/nuts, etc.) \_\_\_\_\_

Other Allergies \_\_\_\_\_

Have you been diagnosed with Fibromyalgia? \_\_\_\_\_

Check all that apply:

- |   |                                    |   |   |
|---|------------------------------------|---|---|
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Pregnant  | <input type="checkbox"/> Stress             | <input type="checkbox"/> Diabetes       |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Bursitis  | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Contact Lenses |
| <input type="checkbox"/> TMJ Disorder       | <input type="checkbox"/> Edema     | <input type="checkbox"/> Contagious Disease | <input type="checkbox"/> Foot Problems  |
| <input type="checkbox"/> Heart Problems     | <input type="checkbox"/> Sinuses   | <input type="checkbox"/> Joint Pain         | <input type="checkbox"/> Osteoporosis   |
| <input type="checkbox"/> Low Back Pain      | <input type="checkbox"/> Sciatica  | <input type="checkbox"/> Varicose Veins     | <input type="checkbox"/> Numbness       |
| <input type="checkbox"/> Bruise Easily      | <input type="checkbox"/> Migraines | <input type="checkbox"/> High Blood Prsr    | <input type="checkbox"/> Foot Problms   |
| <input type="checkbox"/> Skin Disorders     | <input type="checkbox"/> Lupus     | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Depression     |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Dentures  | <input type="checkbox"/> Kidney Problems    | <input type="checkbox"/> Pacemaker      |

Have you had any injuries within the last 72 hours? Please explain \_\_\_\_\_

Do you experience frequent or constant pain? \_\_\_\_\_

Are you taking any medications that could influence our work? (Pain medication, tranquilizers, etc.) \_\_\_\_\_

Have you ever had surgery? \_\_\_\_\_

How do you perceive your level of stress:

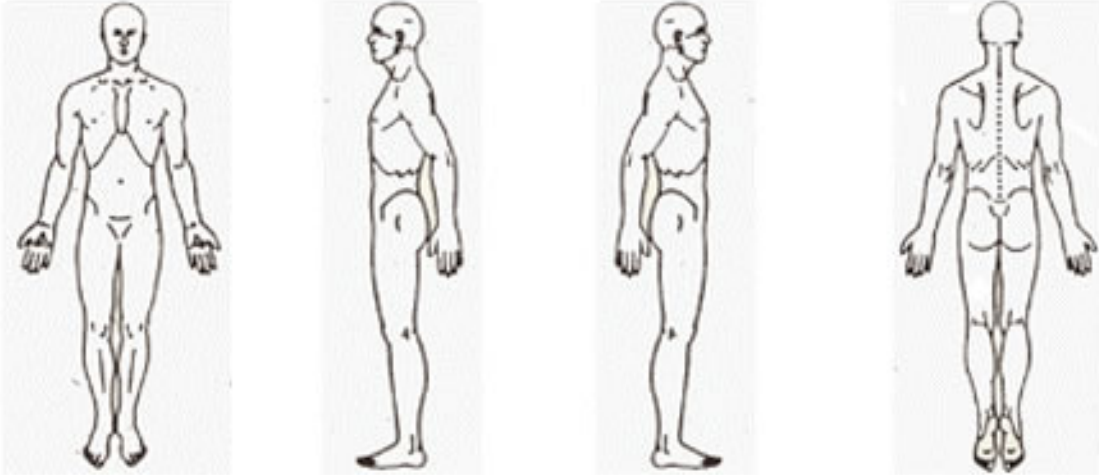
Low 1 2 3 4 5 6 7 8 9 10 High

How do you cope with stress? \_\_\_\_\_

Is there anything else in your history that could impact our work together of which I should be aware? \_\_\_\_\_

Do you have any of the following today:

- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> Headache     | <input type="checkbox"/> Sunburn             | <input type="checkbox"/> Cold/Flu                |
| <input type="checkbox"/> Inflammation | <input type="checkbox"/> Poison Ivy          | <input type="checkbox"/> Nausea                  |
| <input type="checkbox"/> Severe Pain  | <input type="checkbox"/> Irritated Skin Rash | <input type="checkbox"/> Open Cuts/Bruises/Burns |



Please indicate where you are feeling any discomfort

**INFORMED CONSENT: Please take a moment to read the following:**

The above information is accurate to the best of my knowledge and I freely give my permission to be massaged. Massage is contraindicated for some serious medical conditions. It may be necessary to obtain a doctor's release or prescription before beginning therapy. I agree to inform the therapist of any experience of pain during the session. Also, that it is my responsibility to keep my massage practitioner informed of any changes in my health, and any medications that I may begin to take in the future. I understand that I will be properly draped at all times, except the area being worked and that the massage is not sexually oriented in any way. Any illicit or suggestive remarks or behavior on my part will result in immediate termination of the session with full payment expected. I give my consent to receive the treatment discussed in this and all future sessions and agree that my presence at subsequent sessions shall be construed to be validation of this written consent.

48-hour notice of cancellation is required. No shows and late arrivals will be charged amount of full session and will not receive an extension of scheduled service time. This is YOUR Time!! If you are uncomfortable with ANYTHING at ANY TIME, please inform your therapist.

Signature \_\_\_\_\_ Date \_\_\_\_\_