CLIENT MASSAGE INTAKE FORM
ACUITY MASSAGE & ADVANCED SKIN CARE, LLC

ALL INFORMATION BELOW IS PROTECTED BY CURRENT COLORADO STATE HIPAA REGULATIONS AND WILL NOT BE SHARED WITH ANYONE WITHOUT YOUR CONSENT

NAME: _____ D.O.B _____ DATE: _____
ADDRESS: _____CITY_____STATE_____ ZIP _____PHONE #: _____ CELL _____
EMAIL ADDRESS: _____OCCUPATION:_____

May we call you to follow up on treatment results? _____ May we contact you about specials, "thank you" discounts for referrals, or events?____ If yes, how would you like us to contact you?
_____

Emergency contact: _____ Relationship_____ Phone#_____
Health Care Provider _____

Were you referred to our office? ____ By whom?_____ Address _____
May we send them a "thank you for referring you to our office? _____

Have you ever had a massage before? _____ How long ago? _____
Primary reason for your visit today? _____
What results do you expect from today's visit? (relaxation/pain relief, etc) _____

Do you have an important event in the near future? (wedding, graduation, etc) _____

Do you have any special needs or requests? _____

Are you taking any medications/herbs (includes aspirin, ibuprofen, supplements)? Please list
_____

We want to give you the best possible treatment possible. To avoid stimulating or aggravating a current condition we would like to know if you have any chronic systemic illnesses that we should be aware of? (examples: Hepatitis, Epstein Barr, etc.)
_____

If so, have you been released by your physician? ____ Are you <u>currently</u> under a physician's care for an injury/illness?_____

Do you have any allergies to medications, lotions, detergents, cleaning products, etc?
_____
We occasionally use aromatherapy or essential oils during our treatments. Do you have any sensitivities to any scents or products that are scented?_____

Have you ever had any injuries or surgeries? Please list occurrence and date: _____
_____

Please mark below a (C) for current conditions and (P) for past conditions:

Headaches/migraines ____ Allergies ____ Neck Pain ____ Back pain _____

Spinal column disorders ____ Sprains/strains _____ Muscle/joint pain _____

Muscle/bone injuries ____ Arthritis/tendonitis ___ Numbness/tingling __

Heart/circulatory disorders ___High/Low Blood Pressure___Blood thinners ___

Diuretics _____ Chronic pain ____ TMJ ____ Varicose/spider veins ____

Diabetes ____ Clotting disorders _____ Cancer/tumors ____ Asthma or Lung

Conditions ____ Indigestion/Heartburn/Hernia __ Constipation/diarrhea ___

Crones disease ____ Thyroid problems ___ Infectious diseases ____ Athletes foot ____

Hearing problems/deafness ____ Depression ____ Anxiety/Stress ____ Menopause ____

PMS _____ Insomnia ____ Sinus problems ____ Pregnancies ____ Vision problems or

contacts____Dental bridges, braces ____ Birth Control ____ Skin Conditions____

Acne ____ Rashes ____ Cold sores ____ Rosacea ___Claustrophobia ____

Light sensitivity (skin or eyes) ___ Other medical conditions not listed: _____

Please list all forms and frequency of stress reduction activities, hobbies, exercise or sports participation: _____

It is important that you drink plenty of water after a massage. Massage promotes circulation of blood, lymph and in some cases intestinal matter. Water helps clear toxins and keeps you feeling your best. It is recommended that you drink half your body weight, daily, in ounces of water. This does not mean coffee, tea, soft drinks, etc.

Please take a moment and carefully read the following information, circle relationship to client and sign where indicated.

If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to services being provided. I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. Because massage/bodywork is contraindicated (should not be done) 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 practitioner updated as to any changes in my medical profile.

Client, Parent or Guardian Signature: _____Date: _____