DTMC
DEEP TISSUE MASSAGE CENTER

Confidential Client Intake and Health Information Form Date: ___________________

Name: ____ Date of birth: _______________ ☐Male/☐Female
Address: ____
City: ____ State: ____________ Zip: _________________
Daytime Phone #: ____________________ Evening Phone #: ___________________ Email: __________________________
Who referred you to this office? Name: ____
Present symptoms: Please list in order of importance? Date symptom began:

1. ____ __________________
2. ____ __________________
3. ____ __________________

Was there an event that brought it on (e.g. car accident, fall, surgery etc.)? ____
____
What activities aggravate the condition (e.g. standing, sitting, certain movements)? _______________________________
____
Is this condition getting worse? ☐ Yes ☐ No Please Explain: ____
Does this condition interfere with: Work? ☐Y ☐ N Sleep? ☐ Y ☐ N Daily Routine? ☐Y ☐ N
Please explain: ____
Have you experienced any of the following in the past three months: Numbness? ☐ Tingling? ☐ Swelling? ☐
Please explain: ____
Have you had X-rays or other scans taken? ☐ Yes ☐ No
If yes, who ordered them and where were they taken? ________________________________/__________________________
Has there been a medical diagnosis? ☐Yes ☐ No If so, by whom? ____
Have you had any broken bones? If so: Where? ___________________________________ Date:________________________
Have you had any joint injuries? If so: Where? ____________________________________ Date: _______________________
Have you had any joint replacements? If so: Where? ______________________________ Date: _______________________
Please list any surgeries within the last 5 years: ____
Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

☐ Blood Clots
☐ Cancer
☐ Immune system deficiencies*
☐ Infections
☐ Varicose veins
(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)
☐ High/low blood pressure
☐ History of strokes
☐ Rheumatoid arthritis
☐ Thyroid issues
☐ Heart Problems
☐ Osteoporosis
☐ Diabetes
☐ Herniated disc
☐ Headaches
☐ Osteoarthritis

Explanations: ____
____
List other therapies you have tried in the past and/or are presently receiving and name of the practitioner:
____/____
____/____
List any medications (including aspirin) and nutritional supplements you are taking: ________________________________
____
List any additional comments regarding your health and well-being: _____________________________________
____

The following conditions are contraindications for massage: (a) uncontrolled high blood pressure, (b) deep vein thrombosis, (c) blood clots, (d) congestive heart failure, (e) recent soft tissue injuries, (f) recent fractures,
(g) phlebitis and (h) the first trimester of pregnancy. You must notify me of serious illnesses and conditions. You may be asked to bring a letter from your doctor stating your medical condition would not be contraindication for massage. I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client Signature: ________________________________

Massage Client Waiver

Please take a moment to read and initial all of the following statements:

If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure can be adjusted to my level of comfort. I will not hold my therapist or the Deep Tissue Massage Center responsible for any pain or discomfort I experience during or after the session. _____

I understand that my therapist is not a physician and can assess but cannot diagnose. _____

I affirm that I have notified my therapist of all known medical conditions and injuries. _____

I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's or Deep Tissue Massage Center's part should I forget to do so. _____

I understand that should I cancel an appointment less than 24 hours before the scheduled time or "no show" an appointment, I am subject to a fee of $95 per hour. _____

I have received the policy statement, and have read and agree to the policies therein.

Client name: ______________________________ Client signature: ______________________________

Date: _______________

Therapist name: ___________________________ Therapist Signature: ___________________________

Date: _____________