Outer Peace Wellness & Therapeutic Massage
12 North Main Street, Suite 108, West Hartford, CT
www.outerpeacewellness.com

Massage Intake Form

In order to maximize the effectiveness and safety of each session, your massage treatment will be modified in accordance with the information you provide. Please take the time to carefully fill out this questionnaire. This information will be treated confidentially.

Name: _____ Date: __/__/__

Address: _____ City: _____ State: ____ Zip:____

Home Phone: (___)_____ Cell Phone (___)_____

Date of Birth: __/__/__ E-mail: _____

Occupation: _____ List all sports/exercise: _____

Have you had massage therapy before? _____ Type of pressure preferred? _____

How often do you usually receive massage?_____

Do you experience any difficulty when laying on side/back/stomach?_____

Reason for massage therapy session (explain):_____

Are you under a doctor's care? _____ If so, for what conditions? _____

Have you had surgery recently? _____ When (explain): _____

List all medications/supplements: _____

Any allergies? (especially, to nuts, menthol, skin care products, etc):_____

Are you pregnant? _____ If so, when is your due date? _____

Do you wear contact lenses? _____ Hearing aid? _____ Prosthetic? _____

Emergency Contact- Name: _____ Phone: _____

How did you hear about the office?_____

Please mark "X" for all conditions that <u>currently</u> apply to you, and "P" for <u>past conditions</u>.

_____	High Blood Pressure	_____	Cancer	_____	Bursitis
_____	Skin Disorders	_____	Migraines	_____	Pacemaker/Defibrilator
_____	Broken Bones	_____	Breast Surgery	_____	Edema
_____	Low Blood Pressure	_____	HIV/AIDS	_____	Epilepsy
_____	Varicose Veins	_____	Stress	_____	Constipation/Diarrhea
_____	Herniated Disc	_____	Muscle Pulls	_____	Loss of Balance
_____	Heart Conditions	_____	Arthritis	_____	Phlebitis/Cellulitis
_____	Blood Clots	_____	PMS	_____	Recent eye surgery
_____	Whiplash	_____	Sports Injuries	_____	Osteoporosis
_____	Diabetes	_____	Asthma	_____	Neuropathy/Numbness
_____	Tension Headaches	_____	Painful Menstruation	_____	Sinus Problems
_____	Sciatica	_____	Abdominal Hernia	Other	_____

If you wish to provide more information on any of the above, please do so here: _____
_____

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension, and to increase local circulation and improve the function of muscles and joints. I understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment, and that nothing said in the course of the session should be construed as diagnosis or prescription. I attest that the information I have given is true and accurate. I hold harmless Outer Peace Wellness & Therapeutic Massage, LLC from any complications which may arise from information withheld or inaccurately presented. I agree to keep the therapist updated as to any changes in my medical profile and understand there shall be no liability on the therapist's part should I fail to do so.

Date _____ Signature _____

I understand that there is no sexual aspect to the massage treatment. I also understand that if any inappropriate behavior should occur, the session will be terminated immediately, and full payment will be expected.

Date _____ Signature _____

I understand that I must give 24 hours notice if the need to cancel or reschedule should arise, or I may be charged a $25 cancellation fee.

Date _____ Signature _____

Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Written consent must be provided by parent or legal guardian for any client under the age of 17.

Date _____ Signature of parent/guardian_____