Living Link Massage Therapy Intake Form
All information kept strictly confidential. Please answer as thoroughly as possible.

Name: Cell phone:

Mailing Address: Occupation:

Email : Date of Birth:

Please send me:
Email confirmations and reminders for appointments Yes / No
Email newsletters / resources (no more than 2 / month) Yes / No

Referred by _____ May I thank them for referring you? Yes / No

The following information will be used to help plan a safe and effective massage session for you:

Have you had professional massage before? How recently?

What pressure do you generally find beneficial, if you have a preference? Gentle / Medium / Firm

Do you have any allergies to nuts, oils, lotions, or ointments?

Do you sit for long hours at a workstation, computer or driving? Yes / No

Do you have any specific goals for this massage session? Yes / No
If yes, please explain:

What is your weekly exercise routine, if any?

Are you currently under medical supervision?

If yes, please explain:

Do you see a chiropractor? If yes, how often?

Are you currently taking any medication, prescription or over the counter?

If yes, please list:

Please circle any condition listed below that currently applies to you:

easy bruising	epilepsy	recent accident/injury	headaches/migraines
recent fracture	recent surgery	cancer	diabetes
artificial joint	tendonitis	decreased sensation	sprains/strains
back/neck problems	fibromyalgia	RA/osteoarthritis	high or low BP
TMJ Disorder	carpal tunnel syndrome	depression	anxiety

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?

Consent for Treatment

I, (**print name**) _____ understand that the massage I receive is provided for the basic purpose of relaxation, and relief of stress and muscular tension. If I experience any pain or discomfort during this 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 a 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.

X - Signature of client _____ Date _____

Policies

I understand that 24 hour notice, by phone, email or text is required for all cancellations and reschedules. Unless waived, a fee of 50% of the cost of the massage will be incurred for appointments canceled or rescheduled without 24 hour notice.

If during the intake process the massage therapist thinks that my medical information warrants more information or a doctor's note before continuing, the above cancellation policy does not apply.

If I develop any new, or changes to current, medical conditions preceding any additional appointments made with the massage therapist, I will notify her at the time the appointment is booked.

X - Signature of client _____ Date _____