Fluid Motion Massage Client Intake Form

Name: DOB:

Phone #: Email address:

Address: City/State/Zip:

Occupation:

Emergency contact: Phone #:

Have you had a professional massage in the past? YES  NO

How did you hear about Fluid Motion Massage?

What is your goal for this massage?:

Pressure Preference:  Light  Medium

Please check all that apply:

Skin conditions- rash, hives, skin cancer, eczema, psoriasis

Acute infection/cellulitis

Acute inflammation Location:

Blood clot/DVT in past 6 months Location:

Acute/active/untreated cancer Location/Date/treatment received? ­

Wounds

Kidney failure/Acute or chronic kidney disease

Congestive heart failure

Pregnancy If so, how far along:

Orthopedic surgery Location & Date:

High blood pressure/Low blood pressure

Varicose veins

Breathing problems

Decreased sensation

Rheumatoid arthritis

Chronic venous insufficiency

Fibromyalgia

Cardiac arrhythmia

Hernia

Inflammatory bowel disease

Diverticulitis

Cold or sinus congestion

Lyme Disease

Allergies

Pain Location: Rating: (0-10 scale)

Liver Disease

Headaches

Other:

Are you currently taking medications:  YES  NO If so, please list here:

Consent for Treatment:

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork 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 of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said during the session given should be construed as such. Because massage/bodywork should not be performed with certain medical conditions, I affirm that I have made known all my medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner’s part should I fail to do so. I understand that no inappropriate comments or conduct sexually suggestive in nature will not be tolerated. Any indication of such behavior will automatically end the session with full payment expected. Understanding all of this, I consent to receive care.

Client Signature: Date: