Acupuncture & Wellness of Wisconsin, llc

Massage Client Intake Form

Name:_____Phone:_____ email:_____

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

Date of Birth_____ M____ F____ Occupation:_____

Emergency Contact:_____ Phone:_____

Is this your first professional massage? Y____ N____ When was your last massage? _____

Who may we thank for referring you? _____

Please acknowledge the following by initialing each line:

_____ Cancellations must be made 24 hours in advance. I understand that I will be charged a fee for any appointments cancelled with less than 24-hour notice.

_____ I understand that this massage is not a replacement for medical care and that no diagnosis will be made. I understand that some medical conditions may require a doctor's written approval prior to receiving massage.

_____ This is a professional massage provided by a trained massage therapist. I understand that this massage is for therapeutic purposes, and that any inappropriate comments or sexual behavior will result in the termination of the massage, at which point I will be charged the full session price.

Personal Medical History

Please list any medications you take and their purpose. _____

_____

Please list any surgeries, broken bones, fractures, sprains or injuries you have had. _____

_____

Do you have any chronic or recurring tension areas? Please list them. _____

_____

List any areas where you feel pain with movement or restricted movement: _____

_____

Do you have any personal history of the following? Check all that apply:

___ Insomnia ___ Cancer ___Skeletal Disorder ___Allergies ___Skin Disease/ Sensitivities

___ High Blood Pressure ___Hemophilia/ Blood Disorders ___ PTSD / Survivor of Abuse ___Heart Disease

Please circle if you have the following **today**:

(Burns) (Open Cuts) (Skin Rash) (Athlete's Foot) (Cold Sore/Herpes) (Shingles) (Hepatitis) (Nausea/Vomiting)

(Cold/Flu/Fever) (Contagious Disease) (Severe Pain) (Inflammation) (Pregnancy) (Headache/Migraine)

Signature:_____ Date: _____