MASSAGE INTAKE FORM

Date _____

Name _____
Last *First* *MI*

Street Address

_____

City _____ State _____ Zip _____

Telephone _____ ☐ Home ☐ Work ☐ Cell

Telephone _____ ☐ Home ☐ Work ☐ Cell

Email _____ Birth Date _____

Gender ☐ Male ☐ Female

Occupation _____

Emergency Contact Name _____ Emergency Contact Phone _____

How did you hear about us?

_____

Would you like your email address to be used to alert you of specials, discounts and events? ☐ Yes ☐ No

GENERAL

Please CIRCLE/CHECK any that may apply to your past or recent health:

☐Tingling/Numbness	☐Osteoporosis	☐Carpel Tunnel	☐Cancer (type)	☐Headaches	☐Herniated Disc
☐Hormone Imbalance	☐Asthma	☐PMS Syndrome	☐Thyroid	☐Hypoglycemia	☐Phlebitis
☐Chronic/Acute Pain	☐Hysterectomy	☐Pregnancy	☐Neck Pain	☐Heart Ailment	☐Diabetes
☐Digestive Problems	☐Fibromyalgia	☐Flu/Cold/Fever	☐Hand/Arm Pain	☐Foot/Ankle Pain	☐Insomnia
☐Depression/Anxiety	☐High Blood Pressure	☐Varicose Veins	☐HIV/AIDS	☐Kidney Aliment	☐TMJ Syndrome
☐Infectious Condition	☐Shoulder Pain	☐Epilepsy	☐Ulcerated Colon	☐Bruise Easily	☐Allergies
☐Blood Clots	☐Joint Discomfort	☐Arthritis	☐Skin Disorders/Rashes		

Are you currently under the care of a Health Care Professional? ☐Yes ☐ No

If yes, please provide name and phone number. _____

Please list all surgeries with approximate dates. _____

_____

Please list all prescription/non-prescription medications you are taking at this time.

_____

_____

Please list all vitamins, minerals, or homeopathic remedies you are taking.

_____

_____

Do you exercise regularly? ☐Yes ☐ No If so, What type? _____

_____

Do you wear contact lenses? □Yes □ No

Do you have regular sleeping patterns? □Yes □ No

Do you follow a restricted diet? □Yes □ No

Do you have metal implants or a pacemaker? □Yes □ No
Have you ever had a professional massage? □Yes □ No
If yes, when and what type of massage? _____

_____

What type of massage pressure do you prefer? □Light □ Medium □ Firm

Please list any concerns pertaining to your body:

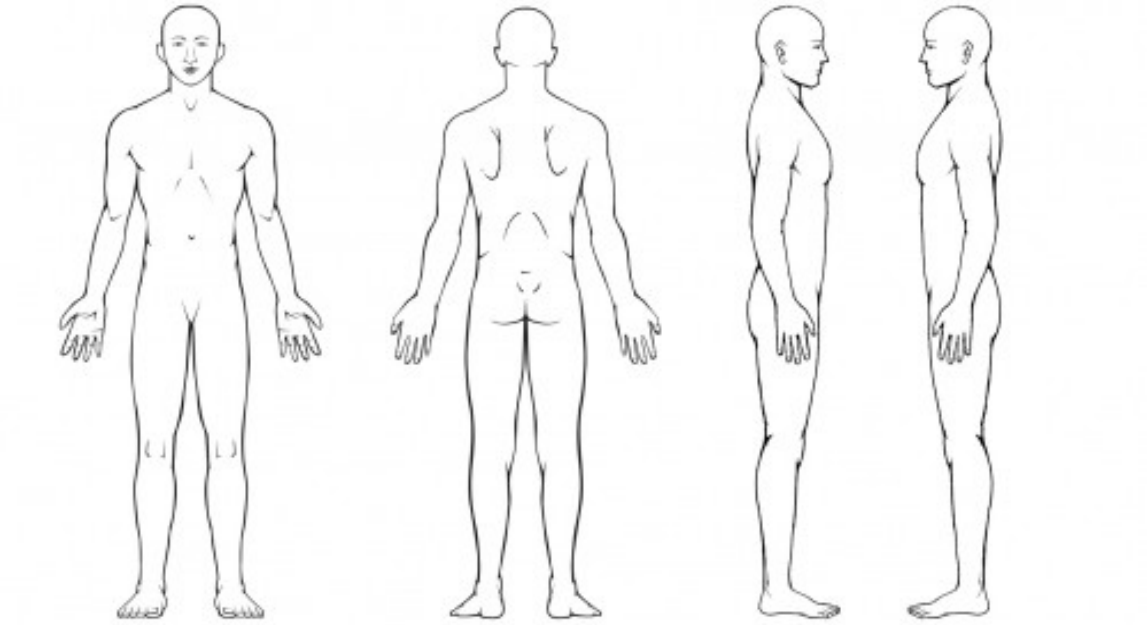
_____

_____

_____

On the diagrams below, please circle those areas that best correspond to the places where you feel you hold stress, tension, or those areas where you may be currently experiencing discomfort or pain.

KEY
A= Ache
B=Burning
S=Sore/Tender
P=Pain
T=Tingling
N=Numb
ST=Stabbing
W=Weakness
X=Stiff/Tight



Cancellation Policy: A 24-hour notice of cancellation is necessary for "pre-payment" for future appointments will be implemented.

I understand if I experience any pain or discomfort during my treatment(s), I will immediately inform the therapist so the treatment can be adjusted to my level of comfort. I further understand that messages should not be construed as a substitute for medical examination, diagnosis, or treatment and I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment I am aware of. I understand massage therapists are not qualified to perform any spinal or skeletal adjustments, diagnose, prescribe, nor treat any physical or mental illness, and nothing said in the course of the session given should be construed as such. I confirm to the best of my knowledge, that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment. I agree to keep therapist updated as to any changes in my medical profile and understand there shall be no liability on the practitioner's part should I forget to do so. It is also understood hat any illicit or sexually aggressive remarks or advances or advances made by me will result in immediate termination of the session, and I will be liable for payment for the "full" schedule appointment.

_____ _____

Client Signature Date

Mirus Massage
3122 W. Cary Street, Suite. A - Richmond, VA 23221
Tel: (804) 537-0166 **Website:** www.mirusmassage.com