Tranquil Touch Healing

Massage Therapy Intake Form

1615 S State Road Cheshire, MA 01225
413.449.6742 www.tranquiltouch.net

Personal Information

Name Date of Birth

Address

City State Zip

Home Phone Cell Phone

Work Phone ext.

eMail

Occupation

Employer

Employer Address

Marital Status If Married, Spouses Name

Referred By

Emergency Contact Name (Relationship) Phone Number

Physician's Name Physician's Phone

How did you hear about us? _____

Have you ever had a professional massage before? _____
If yes, when was your last massage? _____

What type of massage? (ex. Swedish, Deep Tissue, etc)
_____

What is your goal for today?
_____

What type of pressure do you like? (Please Circle)
Light Medium Firm Deep

Are you *uncomfortable* with any of the following areas to be massaged: Yes or No
Gluteal Region _____ Pectoral Region _____
Face/Scalp _____ Feet _____

Current Health Information

Height / Weight: _____

Pregnant? Y / N Weeks? _____

Do you exercise and / or participate in any sports? _____
If yes, what kind of exercise / sport? _____
_____

Do you perform any repetitive movement in your work, sport or hobby? _____
If yes, describe: _____
_____

Do you sit for long hours at a workstation, computer or driving? _____
If yes, describe: _____
_____

Do you experience stress in your work, family or other aspect of your life? _____
If yes, describe: _____
_____

Are you experiencing tension, stiffness, discomfort or pain? _____
If yes, describe: _____
_____

Have you recently had an injury, surgery, or areas of inflammation? _____
If yes, describe: _____
_____

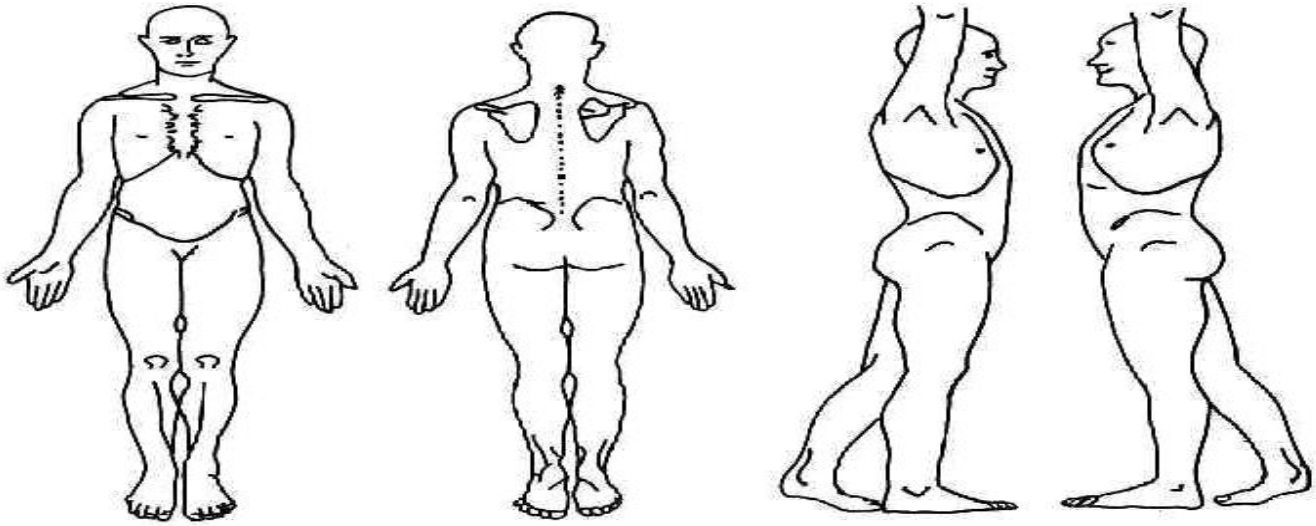
Do you have sensitive skin? _____

Do you have any allergies to oils, lotions, scents or ointments? _____
If yes, describe: _____
_____

List any medications or supplements you are currently taking _____
_____

List any known allergies _____
_____

Please identify the areas of concern on the chart below:



Health History

Please indicate any Present (P), Past (X), or Reoccurring (C) conditions:

_____ ADD/ADHD
_____ Allergies
_____ Alzheimer's disease
_____ Anxiety disorder
_____ Arthritis
_____Osteoarthritis
_____ Rheumatoid Arthritis
_____ Athletes foot
_____ Asthma
_____ Blood Clot/ Deep Vein Thrombosis / Phlebitis/ Embolism

_____ Broken or fractured bones
_____ Bursitis
_____ Cancer
--Location: _____
--Treatment: _____
-- In Remission? Y/N
_____ Carpal Tunnel Syndrome
_____ Cerebral Palsy
_____ Chronic Fatigue Syndrome
_____ Contagious condition
_____ Crohn's disease

_____ Depression
_____ Diabetes
_____ Type I
_____ Type II
_____ Diverticulitis
_____ Eczema
_____ Epilepsy
_____ Epstein Barr
_____ Fertility Concerns
_____ Fibromyalgia
_____ General Fatigue

_____ Gout
_____ Headaches
--Type: _____
--Frequency: _____
_____ Hearing Impairment
_____ Heart Condition
_____ Herpes/ Shingles
_____ High/ Low Blood Pressure
_____ High/ Low Cholesterol
_____ HIV/AIDS
_____ Infection

_____ Lupus
_____ Lymphedema
_____ Mononucleosis
_____ Multiple Sclerosis
_____ Muscular Dystrophy
_____ Numbness/ Tingling
_____ Osteoporosis / Osteopenia
_____ Pain
--Location: _____
--Muscular or Joint: _____
-- Chronic? Y/N

_____ Paralysis
_____ Parkinson's disease
_____ Pregnancy
_____ Psoriasis
_____ Rash
_____ Sciatica
_____ Scoliosis
_____ Seizure
_____ Sleeping problems
_____ Spasms/ Cramping
_____ Strain/ Sprain

_____ Stroke
_____ Tendonitis
_____ Thyroid issues
_____ TMJ/ Jaw Pain

_____ Tumor
--Location: _____
--Malignant or Benign? _____
_____ Varicose Veins

_____ Visually impaired
_____ Other:
_____
_____
_____
_____
_____

Release Form

By signing this, I agree that I have answered all questions to the best of my knowledge and that I will inform the therapist of any changes in my condition or medication. If I experience any pain/discomfort or would like the pressure adjusted, I will inform the therapist immediately. _____

I understand that a massage therapist cannot diagnosis any illness, disease, or any physical or mental disorders nor can the therapist prescribe any medication and that nothing said in a session should be construed as such. I understand that massage therapy is intended to work in conjunction with my health care, not act as a substitute for medical examination. I understand that it is my responsibility to consult a physician for any ailments I may have.
_____

I understand that massage therapy is a therapeutic measure used to reduce stress, muscular tension, and pain. I understand there are no guarantees for recovery and if I am unsatisfied with the progress made with my treatment I will inform the therapist, so he/she may direct me to another treatment. I also understand that massage therapy is non-sexual in nature and any advancement made will terminate the massage. _____

I understand that in the event of a housecall, all pets are to be secured in a room outside of where the massage is taking place. Also, at the time of the massage, I understand that the location must be smoke-free for the health of all involved (therapist and client). _____

I agree to abide by a 24 hour cancellation notice for any scheduled massage. I understand I may be charged up to the full amount of service for missed appointments or for any cancellations with less than a 24 hour notice. I understand that walk-ins are welcome, but does not guarantee the availability for a massage. I understand that if I arrive late for an appointment, the session will end at the original scheduled time to prevent penalizing another client. However, if the massage therapist is late, he/she will fulfill the scheduled massage length or offer a reasonable compensation.
_____

I understand that if I use a coupon during my visit, it is not valid with any other coupons or promotions. _____

I agree that I am of legal age (18 years old) and that if I am not, I agree to have my parent or guardian sign a parental/guardian release form before treatment. _____

I understand that certain conditions or medications may contraindicate (not permit) massage or may require the use of alternate techniques or pressure. I respect the decision of the massage therapist and am fully prepared to reschedule the massage for a later date if requested by the massage therapist. I also understand that massage may be advisable by my physician, but not by a massage therapist. In that event, I agree to provide a written agreement from my physician before proceeding with treatment.

Print Name: _____

Signature: _____

Date: _____