Treasure Coast
Community Acupuncture and Massage

Massage Intake Form

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Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____City/State/Zip _____ DOB _____

Email _____ Emergency Contact _____

Relationship _____ Phone _____How did you hear about us? _____

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: _____

_____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain _____

What makes it better? _____

_____

What makes it worse? _____

_____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: _____

Please indicate any of the following that apply to you.

☐ Cancer	☐ Fibromyalgia	☐ Carpal tunnel
☐ Headaches/ Migraines	☐ Stroke	☐ TMJ
☐ Arthritis	☐ Heart Attack	☐ Sciatica
☐ Diabetes	☐ Kidney Dysfunction	☐ Frozen shoulder
☐ Joint Replacement(s)	☐ Blood Clots	☐ Numbness
☐ High/Low Blood Pressure	☐Sprains or Strains	☐ Neuropathy

Explain any conditions you have marked above:

_____

_____

_____

Massage Information

Have you had a professional massage before? ☐ yes ☐ no

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

Other _____

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ yes ☐no

Please explain _____

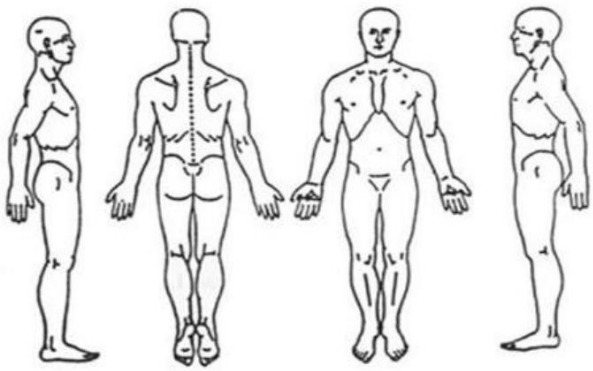
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



By signing below you agree to the following.

I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ *Date* _____

Therapist Signature _____ *Date* _____

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Massage Therapy General Liability Release Form

By signing below, you agree to the following:

1) I give my permission to receive massage therapy.

2) I understand that therapeutic massage is not a substitute for traditional medical treatment or medications.

3) I understand that the massage therapist does not diagnose illnesses or injuries, or prescribe medications.

4) I have clearance from my physician to receive massage therapy.

5) I understand the risks associated with massage therapy include, but are not limited to:
- Superficial bruising
- Short-term muscle soreness
- Exacerbation of undiscovered injury

6) I understand the importance of informing my massage therapist of all medical conditions and medications I am taking, and to let the massage therapist know about any changes to these. I understand that there may be additional risks based on my physical condition.

7) I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so he/she may adjust accordingly.

8) I understand that I or the massage therapist may terminate the session at any time.

9) I have been given a chance to ask questions about the massage therapy session and my questions have been answered.

My participation is done having voluntarily and knowingly assumed all risks involved in the above stated service. In consideration of my voluntary participation, I hereby for myself, my heirs, executors and assigns, WAIVE AND RELEASE the company Community Acupuncture of Florida DBA Treasure Coast Community Acupuncture and the individual contracted, massage therapist from any and all claims for negligence, injuries, damages, or losses that I may incur while participating in the above stated service and any future services.

Signature: _____ Date: _____

Printed Name: _____