Massage Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

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
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement(s)
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Heart Attack
- ☐ Kidney Dysfunction
- ☐ Blood Clots
- ☐ Numbness
- ☐ Sprains or Strains

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 _____

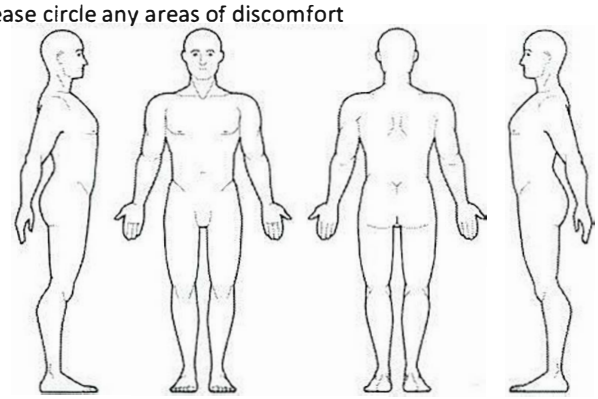
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

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* _____

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

    I therefore release the company and the individual massage therapist from all liability concerning these injuries that may occur during the massage session.
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.

_____ _____

Signature Date

Please email completed form to info@mccarterhealthcenter.com
Or fax to 304-428-5087

McCarter Wellness

Massage Cancellation Policy

We understand that unanticipated events happen occasionally in everyone's life. The following policies will be honored, in our desire to be effective and fair to all clients

No Shows and Cancellations:

Please, understand that other clients may be competing for your appointment time. Please, give 24- hour notice of cancellations, to be courteous to both your therapist and other clients. Excepting emergency situations, missing an appointment without proper notification will result in a charge for your **full** appointment. All fees must be paid before another appointment will be scheduled.

Late Arrivals:

Your session may be shortened in order to accommodate those with appointments following yours. Depending upon how late you arrive, your therapist will then determine if there is enough remaining time to begin treatment. You will be responsible for the **full** session fee, regardless of the length of treatment actually given. Please, plan accordingly and be on time, out of respect for your therapist and fellow clients.

We look forward to serving you!

Client Signature:

_____Date:_____

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