Full Motion LIFE & SPORT

6013-B Wilson Blvd
Arlington, VA 22205
Phone: 703-536-5900

Massage Therapy New Patient Intake Form

Name:_____ Home #:_____

Address:_____ Work #:_____

City-State:_____ Zip:_____ Cell #:_____

Date of Birth:_____ Age:_____ Referred to our clinic by:_____

Occupation:_____ Height:_____ Weight:_____ Gender: ❑ Male ❑ Female

Have you ever received a professional massage or bodywork session? ❑ Yes ❑ No If yes, how recently?_____

In general, what is your preferred level of pressure: ❑ Very deep ❑ Deep ❑ Firm ❑ Light ❑ Unsure

Current Ailments, Afflictions or Significant Past Issues: (*Please check the boxes that apply*)

❑ Chronic stress	❑ Diabetes	❑ Chronic headaches	❑ Epilepsy/seizures
❑ Fibromyalgia	❑ Contact Lenses	❑ Dentures	❑ Allergies
❑ Arthritis	❑ Rheumatism	❑ High blood pressure	❑ Numbness
❑ Joint swelling	❑ Varicose veins	❑ Osteoporosis	❑ Stabbing pains
❑ Contagious disease	❑ Back/neck pain	❑ Asthma	❑ Joint sprain/dislocation
❑ Bruise easily	❑ Chronic pain/fatigue	❑ Circulatory problems	❑ Anxiety
❑ Tendonitis	❑ Tuberculosis	❑ Lymphoma	❑ Cancer
❑ Pacemaker	❑ Blood clots	❑ Kidney/liver disease	❑ Claustrophobia
❑ Bursitis/Gout	❑ Broken bones (past 2 years)	❑ HIV/AIDS	❑ Pregnant (____weeks)

❑ Surgery (When/for what?)_____

Do you have any other medical condition the massage therapist should know about?_____

_____

Current medications you are taking:_____

_____

How would you describe your overall level of stress? ❑ Low ❑ Medium ❑ High How much water do you drink?_____glasses

Any other information that you would like to add:_____

I understand that:

- Missed appointments or appointments cancelled without proper 24 hour notice will be charged to the client at the full rate for which the appointment was scheduled for.
- The relationship between the client and the massage therapist is confidential. All information will be kept confidential.
- My body will be draped at all times for comfort, security and warmth.
- The massage is solely for the purpose of therapeutic massage and that the massage therapist also has the right to be free from any unwanted, harmful, offensive and/or physical contact or behavior.
- I have the right to request and require that any procedure or technique be modified, changed or stopped.
- The information given is accurate and I agree to update the massage therapist if there are any changes in my health or medication.
- It may be necessary to obtain permission from my healthcare provider to receive or continue therapy and there are some conditions for which massage is contraindicated.
- I will inform the massage therapist of any discomfort so that the level of pressure may be adjusted to my level of comfort.
- The benefits of massage and discomfort that I may feel have been explained.
- The massage therapist is state licensed.
- By signing this form, I also give consent for future sessions. I have read this form and freely give my permission to be massaged.

Printed Name:_____ Client Signature:_____ Date:_____