



BLOSSOM & BE WELLNESS RETREAT

Therapeutic Bodywork • Spiritual Development • Women's Health

Client Intake Form Therapeutic Bodywork

Today's Date _____

Name _____ Phone _____

Address _____ City/State/Zip _____

Email _____ Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

How did you find out about us? _____

The following information will help plan a safe and effective sessions. Please answer to the best of your knowledge.

Have you had a professional massage before? Yes No If yes, how often _____

Do you have any difficulty lying on your front, back, or side? Yes No

If yes, please explain _____

What position do you sleep? on belly on side on back move all around

Do you have sensitive skin/ or any allergies to oils, lotions, or ointments? Yes No

If yes, please explain _____

Are you wearing? contact lenses dentures hearing aid

Do you sit for long hours at a workstation, computer, or driving? Yes No

If yes, please describe _____

Do you perform any repetitive movement in your work, sports, or hobby? Yes No

If yes, please describe

What is your typical exercise routine?

What is your typical diet?

Do you experience stress in your work, family, or other aspect of your life? Yes No

If yes, how do you think it has affected your health? _____

Muscle tension anxiety insomnia irritability depression other _____

What are your stress management tools ?

What areas of your body do you experience tension, stiffness, pain or other discomfort?

What specific areas to you want the massage therapists to focus on?

Do you have any particular goals in mind for this massage session? Yes No

If yes, please explain

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Medical History

In planning a massage that is safe and effective, we need some general information about your medical history.

Are you currently under medical supervision? Yes No MD's name _____

If yes, please explain _____

Do you see a chiropractor? Yes No How often? _____ DC's name _____

Are you currently taking any medication? Yes No

If yes, please list _____

Other health team members (PT, LAc) _____

Please check any condition listed below that applies to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> contagious skin condition | <input type="checkbox"/> swollen glands | <input type="checkbox"/> heart condition |
| <input type="checkbox"/> open sores or wounds | <input type="checkbox"/> current fever | <input type="checkbox"/> high or low blood pressure |
| <input type="checkbox"/> accidents / injuries | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> insomnia/sleep disorder/apnea |
| <input type="checkbox"/> surgeries | <input type="checkbox"/> epilepsy | <input type="checkbox"/> carpal tunnel syndrome |
| <input type="checkbox"/> fractures | <input type="checkbox"/> diabetes | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> artificial joints | <input type="checkbox"/> cancer | <input type="checkbox"/> atherosclerosis |
| <input type="checkbox"/> sprains/strains | <input type="checkbox"/> TMJ | <input type="checkbox"/> allergies/sensitivities |
| <input type="checkbox"/> decreased sensations | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> rheumatoid arthritis/osteoarthritis/tendonitis |
| <input type="checkbox"/> back/neck problems | <input type="checkbox"/> tennis elbow | <input type="checkbox"/> deep vein thrombosis/blood clots |
| <input type="checkbox"/> headaches/migraines | <input type="checkbox"/> easy bruising | <input type="checkbox"/> pregnancy - If yes, how many months? _____ |
| <input type="checkbox"/> depression/anxiety | <input type="checkbox"/> phlebitis | <input type="checkbox"/> other _____ |

Please explain any condition marked above (include dates)

Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

- **Draping will be used during the session – only the area being worked on will be uncovered.**
- **Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age 17.**

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this massage session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and my confidentiality may be waived. I also understand that the License Massage Therapy reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

Signature of client _____ Date _____

I want Blossom & Be Wellness articles, newsletters, events and special offers emailed to me: Yes No