Katrina Koleto, LMP
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Confidential Massage Client Intake Form

Name: _____ Pronouns: _____
Phone: _____
Address: _____ City: _____ Zip: _____
Date of Birth: _____ E-mail: _____
Occupation: _____ Hobbies: _____
Emergency Contact:_____ Phone_____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your comfort and knowledge.

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

2. Do you have any difficulty lying on your front, back, or side? Yes No
If yes, please explain: _____

3. Do you have any allergies to oils, lotions, or ointments? Yes No
If yes, please explain: _____

4. Do you have sensitive skin? Yes No

5. Do you consider yourself ticklish? Yes No
If yes, please list areas I should avoid or be careful around: _____

6. Do you sit for long hours at a workstation, computer, or driving? Yes No
If yes, please describe: _____

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please describe: _____

8. Please rate your overall stress level on a scale of 1-10, with 1 being no stress. _____

9. Is stress is affecting any of the following (check all that apply)? muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other _____

10. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort now? Yes No If yes, please identify: _____

_____

10. Do you have any particular goals in mind for this massage session? Yes No
If yes, please explain: _____

_____

11. Circle any of the topics below if you are interested in incorporating them into your massage session (now or later) or learning more about them:

Cupping Essential Oils Stretching Cannabis Topicals Hot Stones

Medical History

12. Are you currently under medical supervision (including chiropractic) or taking any medications? Yes No
If yes, please explain/list: _____
_____

13. Please check any condition listed below that applies to you, now or in the past:

( ) any issues with touch/massage
( ) easy bruising
( ) contagious skin condition
( ) current fever
( ) allergies/sensitivity
( ) high or low blood pressure
( ) varicose veins or phlebitis
( ) PTSD
( ) joint disorder/rheumatoid-arthritis/osteoarthritis/tendonitis
( ) osteoporosis
( ) cancer
( ) decreased sensation/numbness/tingling
( ) Fibromyalgia
( ) open sores or wounds
( ) any major injury or surgery
( ) sprains/strains
( ) swollen glands
( ) heart condition
( ) circulatory disorder
( ) atherosclerosis
( ) deep vein thrombosis/blood clots
( ) motor vehicle accident or other major accident
( )headaches/migraines
( ) diabetes
( ) back/neck problems
( ) TMJ
( ) pregnancy --If yes, how many weeks?

Please explain any condition that you have marked above and 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:
_____

_____

I,_____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. I am at least 18 years of age. **If I experience any pain or discomfort during this session, I will immediately inform the practitioner 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 a physician or other qualified medical specialist for any physical or mental ailment that I am aware of. **I understand that massage practitioners 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 practitioner updated as to any changes in my medical profile in the future and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client_____ Date_____

All information disclosed in this form is confidential and will not be shared with anyone without your express consent and knowledge.