Kilted Paws Massage

Massage Intake form

Please fill out ALL information as thoroughly and accurately as possible.

Name:	Address:	City:	State:	Zipcode:
Email:		Date of Birth: / /		
Phone:		Occupation:		
Whom may we thank for referring you?				

Health and medical information

Please check any that apply to you today or in the past:

	No	Yes		No	Yes		No	Yes
High blood pressure			Osteoporosis			Low back pain		
Low blood pressure			Bursitis			Arthritis		
Blood Clots			Broken bones			Skin Infection/Rash		
Varicose veins			Muscle sprains			Stroke		
Pregnant			Muscle strains			Diabetes		
Contact lens			Headaches			Contagious conditions		
Allergies			Nut allergy			Other conditions		

Please explain any marked YES items	
Prescription medications:	

No	Yes	
		Do you bruise easily?
		Do you suffer from epilepsy or seizures
		Do you have cardiac or circulatory problems
		Do you experience muscle tightness/cramping?
		Do you experience sciatica, numbness, tingling or disc issues?
		Do you experience dizziness, loss of balance or fainting spells?
		Please list any broken bones, fractures, accidents of surgeries within the last 5 years:
		Are you currently under the care of a physician? If **YES**, Why?:
		Have you had a professional massage/bodywork session before? If yes, when and what type?
		Would you like me to focus on or stay away from any specific areas today? If yes, what parts?

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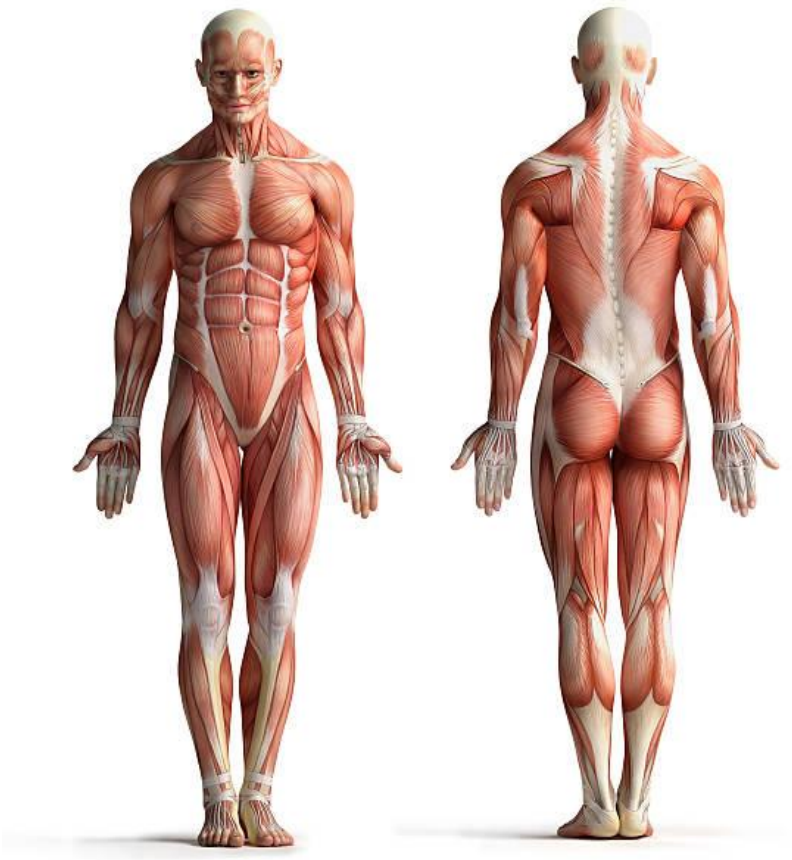
Please fill out ALL information as thoroughly and accurately as possible.

Please indicate with an (X) any areas of your body that are causing you pain or discomfort:



I (initial) _____ attest that the above is true and accurate to the best of my knowledge and will notify the therapist of any updates or changes. I understand that Massage Therapy services are a therapeutic health aid and DO NOT take the place of a physician's care of services when indicated. I understand that immediate termination of this session will take place in the case of illicit sexually suggestive remarks or advances from the client and I will be liable for the full payment of the scheduled appointment. If I am unable to make a scheduled appointment, I agree to cancel within 12 hours, unless I have an emergency. If I miss a scheduled appointment without giving 12 hours notice, I agree to pay for any missed session.

I (initial) _____ have asked my therapist to work on muscles in my groin or chest that are commonly considered "erotic" and off limits for a purely therapeutic reason. I understand that working these muscles is not being done in a sexually suggestive manner and I understand that the session will be terminated immediately if any comments, suggestions or inappropriate remarks are made. I understand that there may be accidental brushing of my sex organs. I understand that my sex organs will not be handled by the therapist. I understand that no "happy endings" are offered during my session. I have requested this be done for the following medical reason:_____

Signature:_____Date:_____