Devine Wellness and Relaxation

Confidential Client Intake and Health History

Full Name: _____ Date: _____

Address: _____ City/St/Zip: _____

Phone (h): _____(w)_____ Date of Birth: _____

Employer: _____ Occupation: _____

Emergency contact: _____ Phone: _____ Relationship: _____

Email: _____ Referred by: _____

*Your email will remain confidential and will not be used for spamming purposes.

Is this your first professional massage? ☐Yes ☐No If no, how frequently do you get a massage? _____

What do you hope to accomplish from today's massage? _____

Are you aware of any tension holding spots in your body? ☐Yes ☐No If yes, where? _____

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago: _____

More than 5 years ago: _____

What kind of care did you receive for your accidents or injuries? _____

Do you feel that you have recovered from these events? _____ Please explain: _____

Do you have any chronic, ongoing pain that you deal with on a regular basis? _____

Please explain: _____

Describe what activities cause this pain and/or make it worse: _____

Are you receiving any other type of medical treatment? _____

_____

Please list any medications (vitamins, herbs or pharmaceutical) taken now or at regular intervals (include explanation of what medication is used to treat): _____

_____

Please list any allergies: _____

Are you currently under the care of a physician? _____ Whom? _____

Please list reason(s): _____

Are there any other health concerns you wish to discuss today? _____ If yes, please describe: _____

_____ TURN OVER ➔

Devine Wellness and Relaxation Medical Waiver

Joelle Espe, LMT MA60547676 Laura Attaway, LMT MA00008394 Crystal L. Whitaker, LMT MA60526101

Your signature below is recognition of the limitations for this and any and all future sessions of bodywork for the duration of the calendar year. It is your responsibility to inform the LMT of any changes to your situation, condition, medication or restrictions as pertains to receiving massage.

I understand that Bodywork is given here for the purpose of relaxation and stress reduction only. I understand that the Licensed Massage Therapist (LMT) does not diagnose illness, prescribe medications or medical treatment or perform purposeful spinal adjustments. The LMT reserves the right to refuse service to anyone for any reason. I also understand that cancelled or missed appointment without 24 hours notice may be charged in full for the price of the missed session.

The LMT cannot perform massage on any person with any of the following medical conditions. (If you have any doubts, please check with your physician prior to receiving a massage.)

- Bacterial/Viral Infections such as: hepatitis, flu, fever, common cold, etc.
- Infectious Skin Diseases such as: poison oak, dermatitis, etc.
- Circulatory/Heart conditions such as: coronary artery diseases, arteriosclerosis, etc.

Conditions with possible exceptions such as high/low blood pressure, diabetes, cancer, etc., must be under control and management from your health care professional prior to receiving massage.

Let your LMT know immediately if during the massage you feel: Light headed, dizzy, nauseous and any excessive or inappropriate pain or discomfort.

Please check any of the following conditions below that currently affect you or that you have experienced in the last **5** years:

MUSCULOSKELETAL
___ Fibromyalgia
___ Spasms ___Cramps Loc: _____
___ Sprains/Strains Loc:_____
___ Osteoporosis
___ Postural Deviations
___ Gout
___ Osteo or Rheumatoid Arthritis
___ TMJ
___ Cysts Location:_____
___ Bursitis
___ Plantar Fasciitis ___R ___L ___ Both
___ Tendonitis Loc:_____
___ Torticollis
___ Whiplash Syndrome
___ Carpal Tunnel Syndrome
___ Sciatica
___ Thoracic Outlet Syndrome
___ Headache Type:_____
___ Leg ___Foot ___Toe Pain
___ Shoulder ___Arm ___Hand Pain
___ Back Pain ___Low ___Mid ___Upper
___ Hip Pain ___R ___L ___ Both
___ Other _____

RESPIRATORY
___ Pneumonia
___ Sinusitis
___ Asthma
___ Trouble Breathing
___ Dizziness
___ Other _____

CIRCULATORY
___ Anemia
___ Hemophilia
___ Blood Pressure ___Low ___High
___ Raynaud's Disease
___ Varicose Veins Loc: _____
___ Heart Condition
___ Blood Clots/Phlebitis Loc: _____
___ Diabetes
___ Other _____

DIGESTIVE
___ Ulcers Loc: _____
___ Irritable Bowel Syndrome (IBS)
___ Colitis
___ Gallstones
___ Hepatitis
___ Crohn's Disease
___ Diarrhea
___ Gas ___ Bloating
___ Indigestion ___ Acid Reflux
___ Other _____

SKIN
___ Fungal Infections/Impetigo
___ Acne
___ Dermatitis ___ Eczema ___ Psoriasis
___ Open Wound or Sore Loc: _____
___ Rash Loc: _____
___ Warts Loc: _____
___ Athletes Foot ___R ___L ___ Both
___ MRSA When:_____
___ Other _____

NERVOUS SYSTEM
___ ALS
___ Multiple Sclerosis
___ Parkinson's Disease
___ Bell's Palsy
___ Neuritis
___ Spinal Cord Injury
___ Stroke
___ Trigeminal Neuralgia
___ Seizure Disorder
___ Numbness ___ Tingling ___ Twitching
Location_____
___ Other _____

OTHER
___ Insomnia
___ Anxiety ___ Panic Attacks
___ PMS
___ Grief Process
___ Cancer _____
___ Substance Abuse
___ Pregnancy ___Current ___ Weeks
___ Prev. Pregnancy ___ VB ___C-Section
___ Chronic Fatigue
___ HIV/AIDS
___ Lupus
___ Kidney Disease
___ Bladder Infection
___ Postoperative Situation
___ Edema Loc: _____
___ Other _____

The above information is accurate and true to the best of my knowledge.
I understand that massage therapy is not a substitute for medical attention or examination.
I have read the above medical waiver and understand that I am receiving massage at my own risk.

***Signature** **Printed Name** **Date**