



Hands On Healing Spa 512.796.6399

Handsonhealingspa.com

Massage Intake

Client Name: _____ Date: _____

Emergency Contact: _____ Phone: _____

Is this massage/bodywork medically necessary (for a medical condition, injury, surgery)? **Y N**

Medical Reason if Yes: _____

Do you have a physician referral/prescription? **Yes No**

Will you need documents for Insurance Reimbursement? **Yes No**

Massage Information:

Have you ever received professional massage/bodywork before? **Yes No**

Date of last massage: _____ (Optional) Location: _____

What types of massage/bodywork do you prefer? _____

What kind of pressure do you prefer? **Light Medium Firm**

Is there anything you do not like about massage? _____

What are your goals/expected outcomes for receiving massage/bodywork? _____

How do you feel today? _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.) _____

Do these symptoms interfere with your activities of daily living (sleep, exercise, work, childcare)? **Yes No**

List Medications you currently take: _____

Are you wearing contacts? **Yes No**

Are you wearing dentures? **Yes No**

Are you wearing a hairpiece? **Yes No**

Are you pregnant? **Yes No** How far along? _____

Continued
➔



Hands On Healing Spa 512.796.6399

Handsonhealingspa.com

Please circle any of the following conditions that apply to you and use lines below to explain:

- | | | |
|-----------------------------|--|-------------------|
| Muscle or Joint Pain | Muscle or Joint Stiffness | Numbness/Tingling |
| Swelling | Bruise Easily | Varicose Veins |
| Sensitive to Touch/Pressure | Headaches | Migraines |
| Epilepsy/seizures | Memory Loss/Confusion | Anxiety |
| Depression | M.S., Parkinson's, Chronic Pain | Dizziness |
| Hearing Issues | Digestive Conditions/ Crohn's | Gas/Bloating |
| Broken Bones | Scoliosis | Allergies |
| Diabetes | Endocrine/thyroid Conditions | Osteoporosis |
| Degenerative Spine/Disk | Arthritis (rheumatoid, osteoarthritis) | Cancer |

Comments: _____

Consent for Treatment

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/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork 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/bodywork 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 and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____