Oversoul Massage Client Intake Form

Name: (Please Print) _____
Phone: _____ Email: _____
Date of Birth: _____ Birth Time (If known): _____ Birth Location: _____
Address: _____
Emergency Contact (Name, Phone, Relationship): _____

Medical History

Current medications and dosage? __ Yes __ No If Yes, please explain below: _____
_____
_____

Any known medical conditions? __ Yes __ No If Yes, please explain below: _____
_____
_____

Any surgeries, hospitalizations or orthopedic injuries in the last 5 years?
_____
_____

Are you pregnant? __ Yes ___ No If yes, how far along? _____ Any risk factors? _____
Do you experience chronic pain? ___ Yes ___ No If yes, explain: _____
Are you currently under the care of a physician? __ Yes __ No
If yes, physician's name: _____ Phone: _____

Indicate any of the following that apply to you:

☐Cancer
☐Headaches/Migraines
☐Arthritis
☐Diabetes
☐Joint Replacement(s)
☐High/Low Blood Pressure
☐Neuropathy
☐Fibromyalgia
☐Stroke
☐Heart Attack
☐Kidney Dysfunction
☐Blood Clots
☐Numbness
☐Sprains or Strains
☐Skin Conditions
☐Contagious Diseases

Please explain any conditions marked above: _____
_____
_____

Massage Information

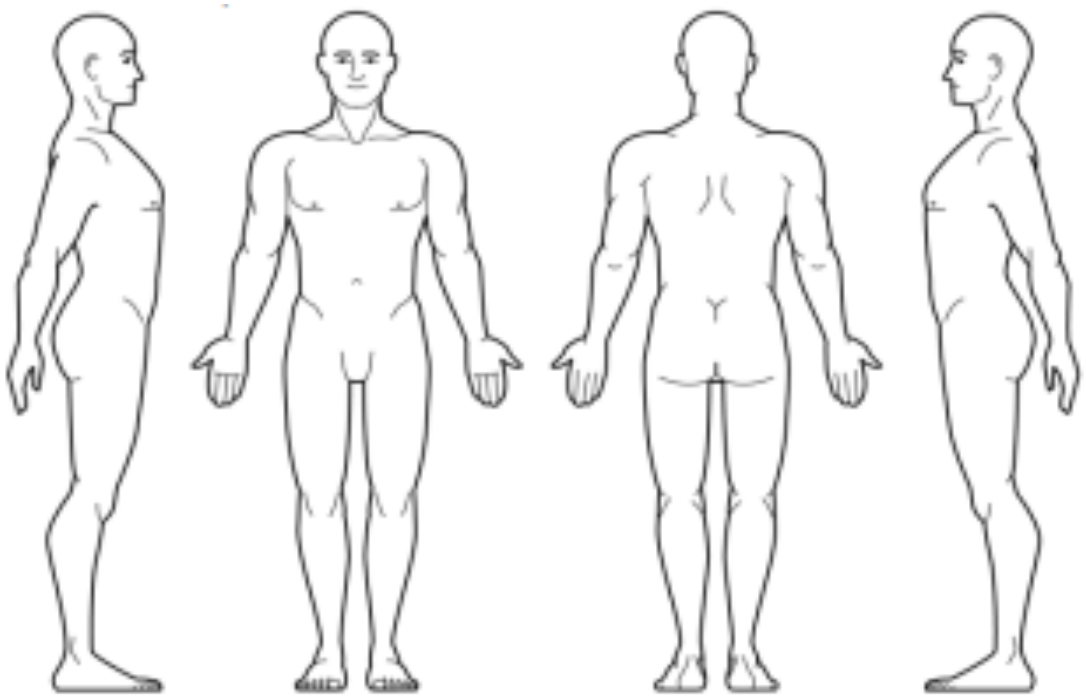
Have you ever received a professional massage? ___ Yes ___ No
If yes, when was your last massage? _____

What type of massage are you seeking? ☐Relaxation ☐Therapeutic/Deep Tissue
Other _____

What pressure do you prefer? ☐Light ☐Medium ☐Deep

Do you have any allergies or sensitivities? ☐Yes ☐No
Please explain _____
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐Yes ☐No
Please explain _____
What are your goals for this treatment session?
_____
_____

Please circle any areas of pain or discomfort:



By signing below, you agree to the following:

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee by the therapist of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis.

I have stated all of my medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand I assume the risk for any medical information not disclosed to my practitioner. I understand that some of my basic personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law or disclosed with my consent to my medical providers.

Client Signature _____ Date _____
Therapist Signature _____ Date _____