



CLIENT INTAKE FORM

The information you provide will enable me to work with you in the most effective manner possible. All information shared, whether on this form or in conversation, is strictly confidential. The only exception made will be for legal purposes if ever necessary. Information for insurance companies will only be released when you have signed a medical release form.

GENERAL INFORMATION

NAME: DATE: DATE OF BIRTH: ADDRESS: PHONE (home): (work): (cell): CITY & STATE: ZIP: REFERRED BY: EMAIL ADDRESS: EMERGENCY CONTACT (name and phone number):

MEDICAL INFORMATION

Have you ever had a professional massage/bodywork before? YES NO If yes, what type of work and when was your last one? Are you receiving chiropractic care? YES NO If YES, please name who you go to Are you receiving any kind of medical treatment or supervision? YES NO If yes, please specify type and reason: Are you taking any medications? (Prescription / Non- prescription) YES NO If yes, what kind? Are you pregnant? YES NO If so, when is the due date? Are you sensitive to touch / pressure in any area? What are your goals for receiving professional massage / bodywork session? Name of your physician

LIFESTYLE

Occupation: What does this involve physically (sitting, lifting, etc.)? On a scale of 1-10 how would you rate the overall stress level in your life? 1 2 3 4 5 6 7 8 9 10 Do you exercise? YES NO. If so, Frequency and type: Do you stretch? YES NO Do you have any comments you'd like to make regarding your experience with any kind of massage therapy/bodywork? Have you had any accidents, injuries, or surgeries

Continued on Back

Please check if you are currently experiencing any of the following conditions

___ Sleep Difficulty ___ Tension ___ Contagious Disease ___ Fever ___ Infection
___ Anxiety ___ Flu/Cold ___ Upset stomach ___ Inflammation ___ Crisis

___ Headaches: Location _____ Frequency: _____ Do you feel they are Migraines or have been told? YES NO
Blurred vision? YES NO. Does light bother eyes? YES NO. Loss of balance/dizziness? YES NO. Ringing in ears? YES NO.
Others? _____

Please check if you have ever experienced or are currently experiencing the following conditions?

Current/Past	Current/Past	Current/Past	Current/Past
___/___ AIDS	___/___ HIV	___/___ Allergies	___/___ Back Pain
___/___ Constipation	___/___ Diarrhea	___/___ Cancer	___/___ Carpal tunnel syndrome
___/___ Epilepsy	___/___ Eczema	___/___ Diabetes	___/___ Disc Problems
___/___ Herpes virus	___/___ Insomnia	___/___ Heart Attack	___/___ Hemophilia
___/___ Numbness	___/___ M. S.	___/___ Arthritis	___/___ Osteoporosis
___/___ Tumors	___/___ Stroke	___/___ Rashes	___/___ Circulation problems
___/___ Sciatica	___/___ Whiplash	___/___ Psoriasis	___/___ Phlebitis/Thrombus
___/___ Skin Allergies	___/___ Bruise easily	___/___ Muscle spasm	___/___ High Blood Pressure
___/___ Tingling	___/___ Tendonitis	___/___ Stiff Joints	___/___ Low Blood Pressure
___/___ Varicose Veins	___/___ Sprain/Strain	___/___ TMJ	___/___ Digestive Problems
___/___ Swelling	___/___ Bursitis	___/___ Addiction	___/___ Muscular Dystrophy
___/___ Chest pain	___/___ Other problems please list: _____		

For Women Only: ___ PMS ___ Menstrual Cramps ___ Lack of period ___ Excessive bleeding Other please list: _____

GETTING TO KNOW YOU BETTER

At European Massage Co. we like to call our clients after their first appointment to see how they are doing. Would you like a call? **YES NO**

Would you like to be scheduled for regular appointments? **YES NO** (We, at European Massage Co., understand how busy your live can get!) If yes **how often** would you like to be called, once a week, once every two weeks, once a month etc.

How often would you like to receive a massage as a part of your health and wellness maintenance program? _____

Client Release

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation, stress reduction and relief of muscular tension and dysfunction. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure may be adjusted to my level of comfort.

I agree that the above information is complete and accurate to the best of my knowledge. I agree to the release of information for legal or medical purposes. I agree to release, or hold harmless, EUROPEAN MASSAGE CO., for any injury that be my responsibility and I agree to pay for these services at the time of treatment.

PATIENT SIGNATURE: _____ DATE: _____

CLIENT INTERACTION POLICY FORM

European Massage values you as “a client” and we also would like to inform you of what we expect from you as “the client”:

1. Sessions will begin and end at scheduled times. If a session is begun late due to the client, it will remain full price, and will end at the scheduled time.
2. Be present (not under the influence of alcohol or drugs).
3. Clients provide a health history and update when necessary. This is important to have accurate information for the best possible treatment.
- 4. If cancellation is necessary, please give 24-hour notice or you are charged for the appointment unless it can be filled. Emergency cancellations are determined at the practitioner’s discretion.**
5. Payment is expected at the time service is rendered.
6. On out-call appointments if a client does not arrive within 15 minutes of the appointed time, he is charged for the appointment.
7. Sexual harassment is not tolerated. If the practitioner’s safety feels compromised, the session is stopped immediately, and you are charged for the full appointment time.
8. This office is a non smoking environment.
9. Come clean, having showered the same day as the treatment.
10. Do not eat a heavy meal less than two hours prior to the treatment.
11. Drink a lot of water before and after the treatment.
12. We encourage you to share in any way how we can better serve you. If you have any ideas of how we could make your service more enjoyable we are open to your comments and ideas. Our clients mean a lot to us so please let yourself be known and let us know how you feel!!

PATIENT SIGNATURE: _____ DATE: _____