Rivercity Pilates Massage Intake Form

Name_____

Date of Birth_____

Address_____

City_____State_____

Zip Code_____

Phone (home, work, or cell) _____

Occupation_____

Email_____

How did you hear about Massage at Rivercity Pilates or who can we thank for the referral?

_____

Have you ever received a professional massage before? Yes No

What pressure do you prefer? Light Med Deep

Any areas you **do NOT** want to have worked?

- Scalp? Feet? Glutes? Upper Pecs (chest)?

What is your#1 goal for today's massage?
- Overall Relaxation
- Pain Relief
- Improved Range of Motion

What is your long term goal?
- Overall Relaxation
- Pain Relief
- Improved Range of Motion

Please list any medications/vitamins/supplements you are currently taking and reason for medications:

_____

_____

Please continue form on back page ⇨⇨⇨⇨⇨⇨

Health Information

Musculoskeletal
- Arthritis/Gout
- Bone or Joint Disease
- Migraines/Headaches
- Osteoporosis
- Scoliosis
- Tendonitis/Bursitis
- TMJ/Jaw Pain
- Plantar Faciitis
- Other_____

Respiratory
- Allergies
- Asthma
- Emphysema/COPD
- Sinus Problems
- Other_____

Circulatory
- Blood Clots
- Heart Condition
- High/Low Blood Pressure
- Varicose Veins
- Other_____

Nervous System
- Carpal Tunnel Syndrome
- Chronic Pain/Fibromyalgia
- Numbness/Tingling
- Pinched Nerve
- Parkinson's Disease
- Chronic Fatigue
- Other_____

Skin
- Athletes Foot/Nail Fungus
- Warts/Plantars Warts
- Herpes/Cold Sores
- Psoriasis
- Rashes
- Shingles
- Allergies (specify):_____
- Sensitivity to Lotions/Oils
- Other_____

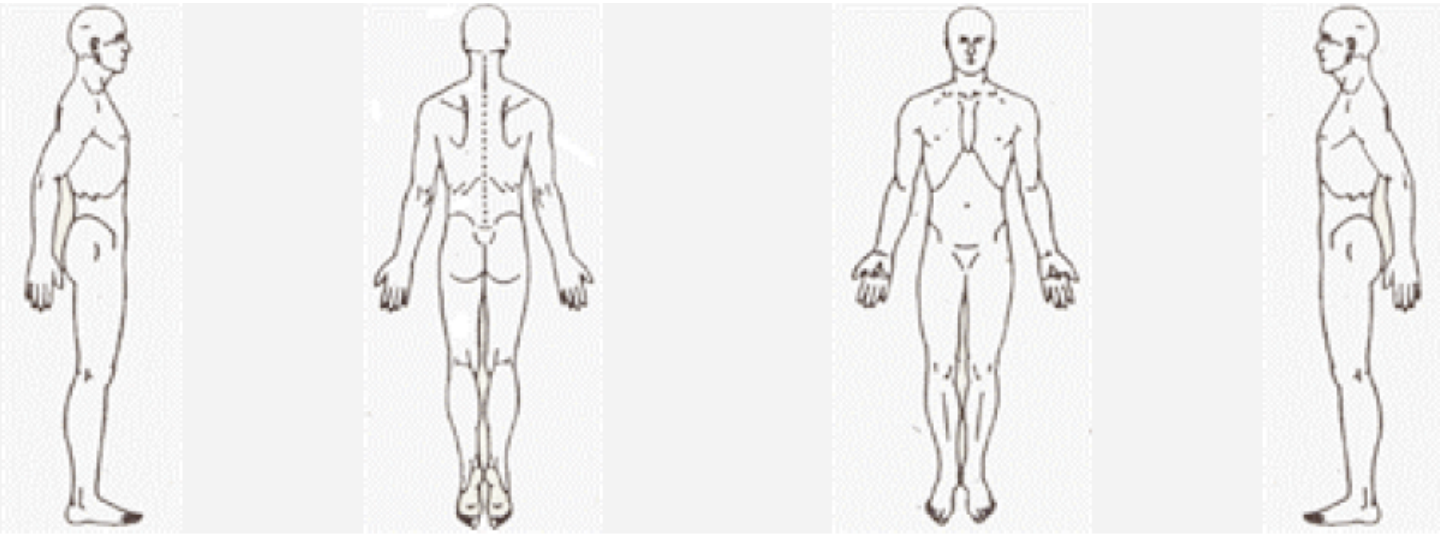
Reproductive
- Menstral Cramps
- Pregnant - # of weeks_____
- Other_____

Digestive
- Ulcers
- Irritable Bowel Syndrome/ Crohn's Disease
- Constipation or Diarrhea
- Other_____

Psychological
- Anxiety/Stress
- Depression
- Insomnia
- Other_____

Other
- Cancer (past or current)
- Diabetes
- Surgeries within the past Year
- Injuries within the past Year

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



Client Agreement

- I understand that the massage given to me by Sara Hinde, is for the purpose of stress reduction, pain reduction, improved circulation, and relief from muscle tension.
- I understand that a licensed massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.
- I understand that massage therapy is not a substitute for medical care, medical examination, or diagnosis and that it is recommended that I work with my primary caregiver for any condition I may have.
- I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments.
- I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes.
- I am aware of the benefits and risk of massage, and I give my consent for massage.

Cancellation Policy

- I agree to give 24-hr notice for a scheduled session that I cannot keep. I am aware that I may be charged the full fee for any missed sessions that I do not give 24hr notice to cancel or reschedule.
- I understand that if I arrive late, my session will end at the originally scheduled time so that the client following me is not penalized.

Signature: _____Date_____

Signature of parent/guardian if client is a minor: _____Date_____