Welcome

Barefoot Massage Intake Form

Personal Information:

Name_____ Phone (Cell)_____ (Home)_____

Address _____ City/State/Zip_____

DOB_____ Email_____ Occupation_____

Emergency Contact_____ Relationship_____ Phone_____

Sex: ☐ Male ☐ Female How did you hear about us?_____

Medical Information:

Are you taking any medication? ☐ Yes ☐ No If Yes, Please list name and use:_____

Are you currently Pregnant? ☐ Yes ☐ No If yes, How far along?_____Any High Risk factors?_____

Do you suffer from Chronic Pain? ☐ Yes ☐ No If yes, Please explain_____

What makes it better?_____

What makes it worse?_____

Have you had any Orthopedic Injuries? ☐ Yes ☐ No If yes, Please list_____

Do you have any metal in the body? ☐ Yes ☐ No If yes, please list where_____

Do you have any allergies/sensitivities? ☐ Yes ☐ No Explain:_____

Have you had anu implants in the last 9 months? ☐ Yes ☐ No If yes, Please list where_____

Have you had a Cortisone shot in the last month? ☐ Yes ☐ No If yes, Please list where?_____

Please 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
☐ Skin Disorders ☐ Implants ☐ Osteoporosis ☐ Hemophilia ☐ Degenerative Disk Disease ☐ Tendonitis
☐ Sprains/Strains Explain any conditions you have marked above: _____
_____.

Massage Information:

Have you had a professional massage before? ☐ Yes ☐ No

Have you had a Barefoot/Ashiatsu massage before? ☐ Yes ☐ No

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

Do you have any allergies/sensitivities? ☐ Yes ☐ No Please Explain_____

Reason for Visit _____ What are you hoping to gain?_____

Rate your pain from 1(least pain) to 10(severe pain)_____

Type of pain:

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning

☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

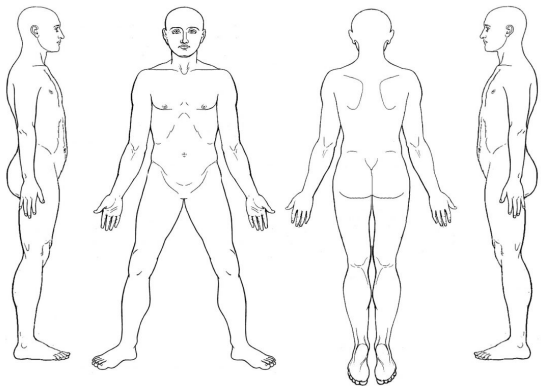
How often do you have this pain?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other_____

Activities or movements that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Turning Neck

Please Circle any Discomfort:



Before your massage session begins, please read the following information to better prepare you for your treatment. The Medical Massage Clinic, consists of certified Massage Therapists trained in Medical MassageTherapy with excellent treatments for the injured patients.

The Medical Massage Clinic would like you to know you are very important to us and that we consider it a privilege to be able to provide you with the highest quality medical massage therapy services. Please take time to read through this information and medical questionnaire. For your comfort, during your massage session please feel free to give your massage therapist any feedback concerning your comfort level. You may ask for more or less pressure according to your sensitivity. Your comfort level is important and your feedback and comments are essential for helping break the pain cycle!

I the undersigned patient understand that this therapeutic therapy session is provided for the basic purpose of relaxation, stress reduction, and most important relief of pain, muscular tension and tightness. If I experience any undo pain or discomfort during the treatment, I will immediately inform the therapist, so the pressure may be adjusted to my best comfort level. I understand that the treatment may cause some undesirable side effects that may occur during or up to 36 hours after the treatment. Some of the effects may be the following:

Slight Headache Nausea Lightheadedness Achy or Sore Muscles

Some interactions are due to an increase of metabolic toxin waste in the circulatory system. This waste may put an extra burden on the excretory system. If this waste and toxins are not flushed out of the system, it will be reabsorbed into the tissue of the muscle. The patients experience may depend on the organs that are being overtaxed. The patient will seldom have a symptom that lasts for any length of time up to 36 hours. I understand that an increase in water intake and other healthful fluids will assist the process of elimination by supplying more fluids for the kidney, colon and lungs. I understand that no treatment performed by the Medical Massage Clinic should be construed as a substitute for a medical examination or diagnosis. I affirm that I have listed and stated all my known medical conditions, and I understand that there shall be no liability on the Medical Massage Clinic.

It is also understood that any illicit or sexally suggestive remarks or advances made by the patient will result in immediate termination of the treatment.

I agree to honor my therapist the respect of their time. If I need to cancel my appointment for any reason I will give a 24 hour notice. If I fail to do so I will be charged $40.

Patient Signature_____ Date_____

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