New Brighton Manor SE,
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403-999-4787

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Pure Serenity
Massage Therapy

Client Intake Form

Name: Date:

Address: City: Postal Code:

Phone: Email:

Date of Birth: (m) (d) (y) Age: Gender:

Occupation: Employer:

Family Dr. Dr. Phone:

Emergency Contact: Phone:

Relationship: How did you hear about us?:

Medical History and Symptom/Pain Information

Reason for today's visit: ◯ **New Injury** ◯ **Old Injury** ◯ **Chronic Pain** ◯ **Wellness**

Is this your first visit?: ◯ **Yes** ◯ **No** Have you had a professional massage before?: ◯ **Yes** ◯ **No**

Rate your pain on the following scale: None 1 2 3 4 5 6 7 8 9 10 Intense

Are you under medical supervision? If so, please explain:

Are you pregnant?: ◯ **Yes** ◯ **No** If so, how many months?: Due Date:

High risk factors:

Do you exercise?: ◯ **Yes** ◯ **No** If so, how many times per week:

What types of excersise/activities do you partake in?:

Do you perform repetitive movements in your work, sports, or hobby?: ◯ **Yes** ◯ **No**

If so, please describe:

Do you see a physiotherapist?: ◯ **Yes** ◯ **No** If so, how often?:

Do you see a chiropractor?: ◯ **Yes** ◯ **No** If so, how often?:

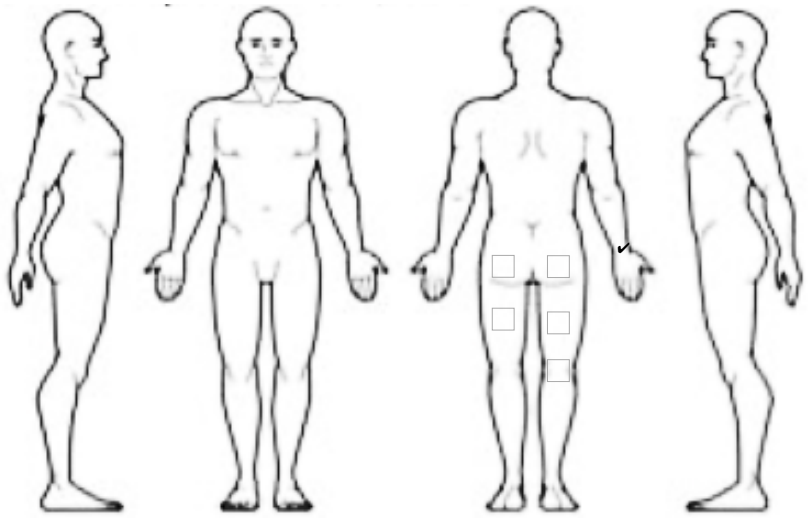
Symptoms you have experienced in the past 6-12 months:

- [ ] **Back Pain**
- [ ] **Neck Pain**
- [ ] **Migraines**
- [ ] **Stroke**
- [ ] **Tension Headaches**
- [ ] **Whiplash**
- [ ] **Allergies**
- [ ] **Hypertension**
- [ ] **Recent Cold/Flu**
- [ ] **Decreased Sensation**
- [ ] **TMJ Disorder/Jaw Pain**
- [ ] **Vertigo/Dizziness**
- [ ] **Recent Surgeries**
- [ ] **Ruptured/Bulging Disc**
- [ ] **Epilepsy/Siezures**
- [ ] **Inflammation**
- [ ] **Arthritis**
- [ ] **High Blood Pressure**
- [ ] **Low Blood Pressure**
- [ ] **Asthma**
- [ ] **Fybromyalgia**
- [ ] **Carpal Tunnel Syndrome**
- [ ] **Bursitis**
- [ ] **Anxiety**
- [ ] **Eczema**
- [ ] **Mastectomy**
- [ ] **Breast Implants**
- [ ] **Gout**
- [ ] **Tendinitis**
- [ ] **Blood Clots**
- [ ] **Bruise Easily**
- [ ] **Osteoporosis**
- [ ] **Varicose Veins/Thrombophlebitis**
- [ ] **Kidney Disorder**
- [ ] **Previous MVA/Trauma**
- [ ] **Cancer**
- [ ] **Diabetes**
- [ ] **Heart Condition**
- [ ] **Bone/Joint Injuries**
- [ ] **Blood Clots**
- [ ] **Bruise Easily**
- [ ] **Sprain/Strain**
- [ ] **Heart Attack**

Please explain any checked above:

If you have any other medical conditions your therapist should be aware of please list:

Please click on the areas to indicate your areas of pain:



Side Front Back Side

What areas do you want to focus on today?:

Type of massage you are requesting: ☐ Swedish/ Relaxation ☐ Deep Tissue ☐ Theraputic Massage ☐ Pregnancy Massage

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

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Massage Therapy

Massage Therapy Agreement

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and or strokes may be adjusted to my level of comfort. I further understand that massage 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 that I am aware of.

I understand that massage therapists are not qualified to perform spinal, 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 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

I understand that draping will be used during the massage session and only the area being worked on will be uncovered. The massage therapist will not perform breast massage on female clients without the written consent of the client prior to the massage session.

If uncomfortable for any reason the client or the therapist may ask to end the massage session immediately.

Print Name: _____ Signature: _____ Date: _____

(Parent or Guardian if under the age of 18)

Therapist Signature: _____ Date: _____