Well-Grounded
Massage + Bodywork

Client Intake Form

Date of Visit _____

Name _____

Birth Date _____

Email _____

Phone _____

Emergency contact _____ Phone _____

Primary Care Provider
Name + Contact (optional) _____

Preferred Pronouns: Please circle one or indicate other (she/her) (he/him) (they/theirs): _____

How did you learn about us? _____

Have you received massage therapy or bodywork before? ☐ Yes ☐ No If yes, when was last session? _____

Are you on any medication? ☐ Yes ☐ No If yes, please list _____

How would you rate your overall health? ☐ Excellent ☐ Fair ☐ Good ☐ Poor

Please list any major accidents, surgeries, injuries and dates of ocurrence

_____

_____

_____

Do you have any allergies or sensitivities to aromatherapy or sesame oil? _____

_____

What is your primary reason for seeking bodywork today?

_____

**Please mark any of the following conditions you may currently have

- ☐ Headaches/Migraines
- ☐ Infection
- ☐ Currently pregnant
- ☐ Vertigo/dizziness
- ☐ Sinus congestion
- ☐ Fever within 24 hrs.
- ☐ Cold virus / COVID-19/Flu
- ☐ Allergies
- ☐ Alcohol within 24 hrs.
- ☐ Recent surgery
- ☐ Open wounds
- ☐ Neck injury/Whiplash
- ☐ Fracture/Broken bone
- ☐ Numbness/Tingling
- ☐ Wear Contacts
- ☐ Other (Specify below)

_____

- ☐ Sciatica
- ☐ Joint hypermobility
- ☐ Degenerative Disc/Herniation
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Pins/Plates/Wires/Artificial Joint
- ☐ Asthma or Respiratory condition
- ☐ Cosmetic implants
- ☐ Tendonitis
- ☐ Ankolysing Spondylitis
- ☐ Jaw Pain (TMJ)
- ☐ Scoliosis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue Syndrome
- ☐ Depression
- ☐ Anxiety/PTSD
- ☐ Grief Process

- ☐ Acute skin condition (ie. Poison Ivy)
- ☐ Hepatitis
- ☐ Lyme Disease
- ☐ HIV/AIDS
- ☐ Herpes
- ☐ Tuberculosis
- ☐ High or Low blood pressure
- ☐ Heart condition
- ☐ Stroke
- ☐ Phlebitis/DVT/Varicose veins
- ☐ Poor Circulation
- ☐ Blood Clot
- ☐ Seizures/Epilepsy
- ☐ Pacemaker or other implant
- ☐ Digestive condition
- ☐ Diabetes
- ☐ Cancer

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Informed Consent + Liability Waiver

Please sign and date the Informed Consent/General Liability Waiver Below.

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 massage therapy is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment nor perfom spinal manipulations.

I understand that there is no implied or stated guarantee 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 medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Signature _____ **Date** _____