Bloomfield
Total Health Center
The Ultimate in Health & Wellness

Massage Therapy Intake Form

Name: _____ M | F D.O.B. _____

Address: _____

E-Mail: _____

Phone: _____ Cell: _____ Work: _____

Returning Client Y | N How did you find us? _____

Have you ever had any injuries (broken bones, torn ligaments, surgeries?) When?

_____

Do you currently have any of the following medical conditions?

____ Pregnancy _____ Tendonitis/Bursitis _____ Skin disorders ____ Infections _____ High Blood pressure
____ Low Blood pressure. ____ Heart conditions ____ Asthma _____ Blood clots _____ Arthritis
____ Diabetes _____ Cancer ____ Surgery (Please explain below) ____ Other (Please explain below)

_____

What medications are you currently taking?

_____

Did you take any medication today? If so, what medication and what time?

_____

Do you have any allergies or sensitivities to oils, lotions, scents or foods?

_____

What are the appropriate areas of concern?

____ Head	____ Upper Back	____ Knees	____ Legs/Thighs
____ Neck/Shoulders	____ Lower Back	____ Feet/Ankles	____ Other

Additional Comments:

_____

_____

_____

By signing this consent form, I understand that Bloomfield Total Health Center's Massage Therapist DOES NOT diagnose illness, disease or any other medical disorder. As such, the Massage Therapist DOES NOT provide medical treatment or pharmaceuticals. I understand that any services provided are not a substitution for medical treatment and that I should see a physician for any physical ailment that I might have. Because the Massage Therapist must be aware of any existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the therapist updated with regard to my physical health. Therefore, I assume all risk for my health and hold harmless Bloomfield Total Health Center's Massage Therapist or any persons involved in services performed.

I also understand that any illicit or sexually suggestive remarks and/or advances made to the Massage Therapist in the Massage Room at any point will result in immediate termination of the session and/or removal from the treatment room. In this case I will be held liable for payment "In full."

I acknowledge Bloomfield Total Health Center maintains a 4 hours Cancellation policy. If I choose to cancel services in less than 4 hours, I am responsible for the full amount of service fees.

I understand that questions about service procedures and recommendations are encouraged and welcomed.

Signature: _____ Date: _____

Print Name: _____ Provider Initials: _____