Client Intake Form

Just Wellness, LLC
104 Broadway, first floor, Hanover, PA 17331

Name:____________________________________ Date:________________________

Address:___________________________________ City:________ State:______ Zip:______

Phone Number:__________________________ Cell Phone:________________________

Email:________________________________ D.O.B.____________ Age:_____ Male Female

Emergency Contact Name & Phone Number:____

Referred By:__________________________________

I understand that the massage given to me is for the purpose of stress reduction, pain reduction, relief from muscle tension, increasing circulation, or specific reasons discussed between my therapist and I. If I experience any pain or discomfort during the session, I will ***immediately*** inform my massage therapist. Any burns, bruises, broken bones, worsening of symptoms, on coming of disease, or allergic reactions will not be the fault of the therapist.

I understand that the 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 and that it is recommended that I work with my primary caregiver for any condition I may have.

I understand that if I am late to an appointment that the accumulated time will be deducted from my scheduled appointment.

I understand that any Sexual Innuendoes, language and behavior will <u>not be tolerated</u>. Session will end immediately and client will be charged full price if such an occurrence take place. We hold the right to refuse future services.

I understand that according to The State Board of Massage Therapy in the state of Pennsylvania, " Use safe and functional coverage/draping practices during the practice of massage therapy when the client is disrobed. Safe and functional coverage/draping means that the client's genitals and gluteal cleft and the breast area of female clients are not exposed and that massage or movement of the body does not expose genitals, gluteal cleft or breast area. With voluntary and informed consent of the client, the gluteal and breast drapes may be temporarily moved in order to perform treatment of the area."

I understand the therapist is allowed to discontinue treatment at anytime they deem fit.

All information is confidential unless authorization for release of information is requested by client.

Client Signature:____________________________________ **Date:**_______________

Therapist Signature:_________________________________ **Date:**_______________

(Please see reverse side)

Occupation:______________________________ Family Physician:______________________________

What's the reason for your visit today?______________________________

Have you received a massage before? Yes No How long since your last massage?__________________

Are you currently involved in other forms of therapy? Yes No If yes what kind?__________________

Any recent injuries? Yes No If yes what kind?______________________________

Any type of surgery? Yes No If yes what kind?______________________________

Have you had lymph nodes removed, injured or radiated? Yes or No

If so, where?______________________________

Do you get Migraines? Yes No How often?______________ Have you been Diagnosed? Yes No

Do you get Headaches? Yes No How often?______________

Are you pregnant? Yes No If Yes what trimester? ______________________________

Do you have any conditions that your therapist needs to be aware of? Yes No If yes what kind?__________

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Do you have any allergies? Yes No If yes what kind?______________________________

Are you currently taking any medications/vitamins? Yes No If yes what kind?__________________

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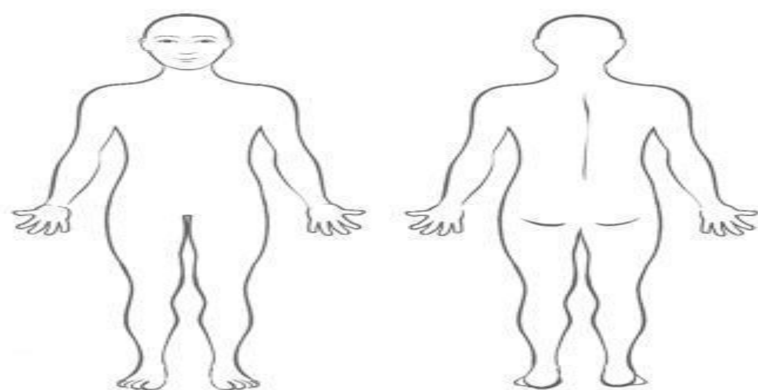
Do you exercise? Yes No If yes how often?______________ Daily water intake:__________________

Please Circle all that apply to you.

Arthritis	Dizziness	Heart Condition	Herniated Disk	Bursitis
Ringing Ears	Low Blood Pressure	Neck Pain	**Cancer**	Fainting Spells
High Blood Pressure	Back Pain	Loss of Balance	Shortness of Breath	Chest Pain
Edema	Fatigue	Muscular Disorders	Sciatica	Diabetes
Cold /Numb Feet	Sinusitis	Constipation	Depression	Fibromyalgia
Abdominal Hernia	Blood Clots	Broken Bones	Allergies	Varicose Veins



Please Circle any areas that cause pain or discomfort.

Any additional comments here:______________

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I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes.

Client Signature:______________________________Date:__________________