WestLake Massage

-Client Intake Form-

Name_____ DOB_____ Today's Date_____

Address _____

Telephone _____ Type: Home Cell Office

Email _____

Occupation _____

Do you sit in one place/position for the majority of the day? (Yes/No) _____

Do you have any areas of the body to avoid? _____

Do you have any areas of the body needing focus? _____

Circle Your Stress Level: High Average Low None

Have you had massage before? (Yes/No) If yes, when? _____

What's your goal for today's visit (relaxation, pain relief, etc.) _____

How did you hear about Westlake massage? _____

(Please check mark if you presently have any of the following conditions)

__Heart disease
__High or Low Blood Pressure
__Liver, Kidney, or Digestive issues
__Respiratory infections or diseases
__Cancer or Tumors
__Fibromyalgia or Chronic Fatigue
__Strokes
__Headaches
__Impaired Immune System
__Rheumatoid/Osteoarthritis
__Neurological (Parkinson's MS, Seizures)
__Diabetes
__Swelling/Lymphedema
__other (please explain below)

Are You Pregnant? If yes, how many weeks? _____ First pregnancy? _____

Please List Any Allergies: _____

Please list **any** recent Injuries, Surgeries, or Illnesses: _____
_____

List any Medications you are currently taking: _____
_____

Do you exercise regularly? (Yes/No) If yes, how often/what kind? _____
_____

Emergency Contact: _____Phone: _____

Please read carefully and be sure you understand ALL Terms and Conditions:

A massage therapy appointment is provided for the basic purposes of relaxation and reduction of muscular tension. I understand that massage therapists are not qualified to perform spinal adjustments, diagnose, prescribe or treat any medical condition. If I have a specific medical condition, the massage may be contraindicated and a letter of approval from my primary care provider may be necessary prior to the session. If I experience any pain or discomfort, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort. I also understand that massage should not be construed as a substitute for medical diagnosis or treatment and I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware.

I understand the client and therapist both reserve the right to immediately discontinue a session and/or decline future treatments due to ANY form of inappropriate behavior including but not limited to vulgar or sexually suggestive comments and/or actions.

I affirm that I have stated all of my known medical history and agree to keep my massage therapist updated to any changes in my condition, nor shall there be any liability on the therapist's part should I forget to do so.

I am aware of the 24 hour cancellation policy and that I will be responsible for the full cost of session if I do not give at least 24 hour notice of cancellation.

Signature _____

Date_____