Balanced Spirit Massage Therapy & Myofascial Release-Client intake form

Courthouse Office Park, Chelmsford, MA

978-764-1211

Name:_____ Date of birth_____

Address (street): _____

City _____ State _____Zip code_____

Phone: (mobile)_____ __ (other) _____

e-mail:_____

Occupation: _____

Referred by: _____

Emergency Contact: _____

Have you had professional bodywork before? Yes No

if yes, what type? _____

Goal(s) for this session _____

Medical History

_____Allergies (seasonal/food/chemical/medicines)

_____Arthritis _____Circulatory problems ____Cancer (type)_____

_____Diabetes _____Digestive- GERD/constipation/IBD

_____Liver/Kidney /Thyroid issues _____Auto-immune disorder (type) _____

_____Insomnia _____ Headaches/Migraines ____Sinus issues

_____Heart Disease (type) _____

_____High/Low Blood pressure _____Varicose Veins

_____Respiratory issues (bronchitis/asthma)

_____Skin conditions (wound/rash/hives/acne/eczema/psoriasis/shingles)

Do you smoke? Yes No Pregnant? Yes____ #weeks_________

Are you under the care of a doctor or other health care practitioner? Yes No

If yes, name of practitioner____

Current medical condition(s)____

Current medications (prescriptions/herbs) ____

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Please list recent/past injuries, include dates & treatments ______________________________

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Do you have any tension/pain/sensitivity in any particular area? _______________________

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All of the above information is accurate to the best of my knowledge. I understand that any massage/bodywork I receive is for the purpose of relaxation, stress reduction, and relief of muscular tension and is not a substitute for medical examination, diagnosis, or treatment as prescribed by a qualified professional (physician, chiropractor, psychiatrist, etc).

If I experience any pain or discomfort during my session(s), I will immediately inform the practitioner so that pressure/strokes can be adjusted to the level of my comfort.

Because massage/bodywork is contraindicated (should not be done) under certain (medical) circumstances, I agree to keep the practitioner updated on any changes in my health status.

Please note there is a 24 hour cancellation policy. Payment is expected at the time services are rendered. Should I arrive late to my appointment, the practitioner will honor the remaining time of the session, and full payment will be collected upon completion.

____ _______________

Client Signature Date
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