**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primarycare provider may be required prior to service being provided.**

Have you ever experienced a professional massage or bodywork session? \_ Yes \_ No How recently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a chronic or acute injury? \_ Yes \_ No Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, does this interfere with daily activities (i.e work, sleep, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your massage or bodywork goals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What kind of pressure do you prefer? \_\_ Light \_\_ Medium \_\_ Firm **\*Deep is NOT available**

***Check all that apply. If you answer “yes” to any of the following questions,* please explain as clearly as possible*.***

Do you frequently suffer from stress?

Do you have diabetes?

Do you experience frequent headaches?

Are you pregnant? \_\_\_\_\_Weeks \_\_Complications?

Do you suffer from arthritis?

Are you wearing contact lenses?

Do you have high blood pressure?

Do you suffer from epilepsy or seizures?

Do you suffer from joint swelling?

Do you have varicose veins?

Do you have any contagious diseases?

Do you have osteoporosis?

Do you have any allergies?

Do you bruise easily?

Any broken bones in the past two years?

Any injuries in the past two years?

 Do you suffer from back pain?

 Do you suffer from neck pain?

 Do you have TMJD, jaw pain?

 Do you have tension or soreness in a specific area?

 Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you have cardiac or circulatory problems?

 Do you have numbness/tingling/stabbing pains?

 Are you sensitive to touch or pressure in any area?

 Have you ever had surgery? Explain below.

 Have you had any major accidents or traumas?

 Other medical condition, or are you taking any

 medications I should know about?

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications and/or Supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Disclaimer:** This place of business will not be held liable for any injury or condition that arises from application of massage despite completion of this form. The form is intended as an assessment tool only and serves as a guide for the application of massage.

**Cancelation Policy:** By signing this intake form you agree that if you need to cancel or reschedule an appointment, you will provide us with a ***minimum of 24-hours*** notice to avoid being charged a fee. Any cancellations within twenty four hours of your scheduled time will be subject to the current cancellation fee. If you fail to show up for your appointment, and do not call to cancel, you will be charged the full amount of the original massage.

I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I agree to inform my massage therapist immediately of any change in the conditions stated above. I acknowledge that this information is confidential and intended for review by massage therapists; that a medical referral may be requested of me; and that Rubin Family Chiropractic is not liable for the management of any condition. I also understand that any illicit or sexually suggestive remarks or advances made by myself will result in immediate termination of the session, and I will be liable for full payment of the appointment.

**Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If a Minor, Signature of Guardian/Parent is required:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**