Healing Breeze Client Intake Form

Name_____ Phone_____-_____-_____ Text ok? ___Y ___N

Address _____

Email (for special's) _____ Date of Birth ___/___/____

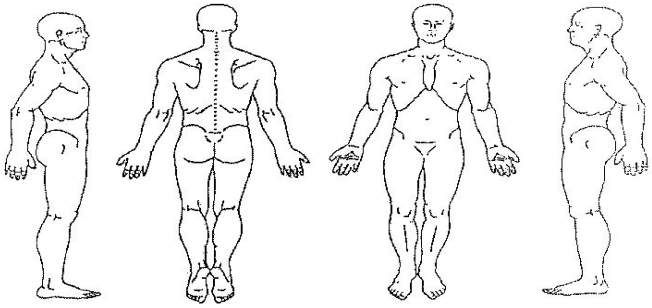
Occupation _____ How did you hear about us? _____

The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge.

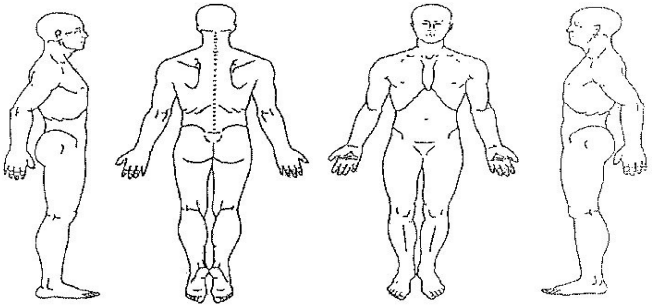
Have you had a professional massage before? ☐ yes ☐ no
Are you taking any medications? ☐ yes ☐ no
Are you currently pregnant? ☐ yes ☐ no
If yes, how far along? _____ Any high risk factors? _____
Do you have any allergies or sensitivities (oils, lotions, ointments, etc.)? ☐ yes ☐ no
Please explain _____

Please check any condition listed below that applies to you:
*Cancer ☐ *Headaches/Migraines ☐ * Arthritis ☐ *Diabetes ☐ *Joint Replacement(s) ☐ * High/Low Blood Pressure ☐
*Neuropathy ☐ * Fibromyalgia ☐ *Stroke ☐ *Heart Attack ☐ *Kidney Dysfunction ☐ *Blood Clots ☐
*Numbness ☐ *Sprains or Strains ☐ *Sciatic Nerve ☐ *Other _____

Please circle any areas of discomfort



Place an "X" over specific areas you want me to avoid during the session.



The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to: *need to move or change position *sighing, *yawning, *change in breathing *stomach gurgling *emotional feelings and/or expression movement of intestinal gas *energy shifts *falling asleep *memories

Please read the following information and sign below:
1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

By signing below, you agree to the following. I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ Date _____
Therapist Signature _____ Date _____