Compassion Massage
THERAPEUTIC CLINIC

CompassionMassage.com

Client Intake Form

Name: _____ **Phone: ( )**_____ **E-Mail:**_____

Address: _____ **City:** _____ **State:**_____ **Zip:**_____

Date of Birth: _____ **Occupation:** _____ **Referred by:** _____

In case of emergency: _____ **Phone: ( )** _____

Chiropractor: _____

General & Medical Information:

If you answer "yes" to any of the following questions, please explain as clearly as possible.

❑Yes ❑No Have you ever had professional massage?

❑Yes ❑No Are you wearing contact lenses?

❑Yes ❑No Are you allergic to any oils, lotions, or ointments? If so please name:
_____

❑Yes ❑No Are you very sensitive to touch / pressure in any area?
_____

❑Yes ❑No Do you sit for long periods of time such as at a desk or in a car driving? If yes, please explain in the comments section.

❑Yes ❑No Have you ever had surgery? If yes, please explain in the comments section.
_____

❑Yes ❑No Do you have any other medical conditions that I should be aware of?

Sleep position(s): _____

Car Accidents: _____
_____

Comments: _____
_____

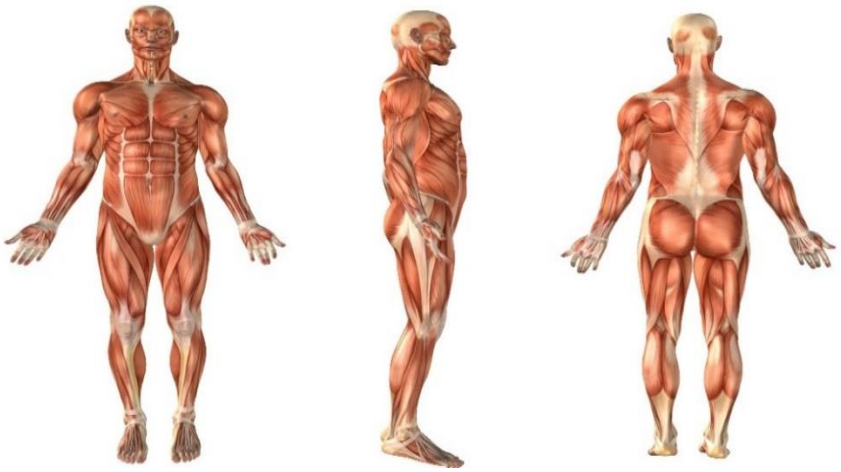
Rate your pain on the scale

0 1 2 3 4 5 6 7 8 9 10

No Pain **Moderate** **Worst Pain**

Define the quality of your pain: (achy, throbbing, tender, radiating, stabbing, tingling, numbness, spasms)

Please circle specific areas you would like the therapist to concentrate on during your session



1137 Main Street
Leominster, MA 01453
(978) 534-0101
info@compassionmassage.com

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Helpful Suggestions to Enhance Your Session:

- Please remove all loose articles of clothing and jewelry
- Your therapist will drape your body appropriately with a sheet and blanket and ensure the room temperature matches your preferred preference.
- We encourage you to give your therapist feedback with regards to the pressure applied to your body during your massage. We strongly encourage you to point out any pain points or ticklish areas on your body.
- At any time during your consultation or during your massage, please feel open to ask questions, this session is about you, your body and your health.

Please Read the Following Disclaimers and Sign:

- It is important to know massage may not be appropriate with certain medical conditions or for injuries to specific body parts.
- If during the session you feel any pain or discomfort, it is highly recommended that you notify your therapist so that treatment pressure can be adjusted immediately.
- Massage is not a substitute for medical examination, diagnosis, or treatment. It is recommended that you seek the attention of a qualified medical professional for any mental or physical conditions that require such attention.
- Massage therapy is not a substitute for care such as spinal or skeletal adjustments, therefore, if you require such treatment it is recommended you consult with a qualified medical professional such as a chiropractor.
- It is important that you keep your therapist current on any changes in your medical conditions as massage is not appropriate under certain circumstances. By signing this form and going through our intake process, you affirm that you have answered all questions honestly and that there is no liability on the therapist in the case you do not disclose any conditions or update him or her with regards to changes in your medical condition that might impact your reason to receive massage.
- Compassion Massage Therapeutic Massage Clinic LLC and its therapists are professional complementary healthcare providers, any comments, suggestions, or solicitation of sexual behavior is grounds for immediate termination of your session without refund.

Client Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

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Health History

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal
o Headaches
o Joint stiffness/swelling
o Spasms/cramps
o Broken/fractured bones
o Strains/sprains
o Back, hip pain
o Shoulder, neck, arm, hand pain
o Leg, foot pain
o Chest, ribs, abdominal pain
o Problems walking
o Jaw pain/TMJ
o Tendinitis
o Bursitis
o Arthritis
o Osteoporosis
o Scoliosis
o Bone or joint disease
o Other: _____

Circulatory and Respiratory
o Dizziness
o Shortness of breath
o Fainting
o Cold feet or hands
o Cold sweats
o Swollen ankles
o Pressure sores
o Varicose veins
o Blood clots
o Stroke
o Heart condition
o Allergies
o Sinus problems
o Asthma
o High blood pressure
o Low blood pressure
o Lymphedema
o Other: _____

Skin
o Rashes
o Allergies
o Athlete's Foot
o Warts
o Moles
o Acne
o Psoriasis
o Cosmetic surgery
o Other: _____

Digestive
o Nervous stomach
o Indigestion
o Constipation
o Intestinal gas/bloating
o Diarrhea
o Diverticulitis
o Irritable bowel syndrome
o Crohn's Disease
o Colitis
o Adaptive aids
o Other: _____

Nervous System
o Numbness/tingling
o Twitching of face
o Fatigue
o Chronic pain
o Sleep disorders
o Ulcers
o Paralysis
o Herpes/shingles
o Cerebral Palsy
o Epilepsy
o Chronic Fatigue Syndrome
o Multiple Sclerosis
o Muscular Dystrophy
o Parkinson's disease
o Spinal cord injury
o Other: _____

Reproductive System
o Pregnancy:
  o Current
  o Previous
o PMS
o Menopause
o Pelvic Inflammatory Disease
o Endometriosis
o Hysterectomy
o Fertility concerns
o Prostate problems

Other
o Loss of appetite
o Forgetfulness
o Confusion
o Depression
o Difficulty concentrating
o Drug use _____
o Alcohol use _____
o Nicotine use _____
o Caffeine use _____
o Hearing impaired
o Visually impaired
o Burning upon urination
o Bladder infection
o Eating disorder
o Diabetes
o Fibromyalgia
o Post/Polio Syndrome
o Cancer
o Infectious disease (please list)
_____
o Other congenital or acquired disabilities (please list) _____
_____
o Surgeries _____
o Other: _____

Please list any additional comments regarding your health and well-being: _____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's Signature: _____ Date:_____

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Prescription Medications

Medication: ______________________________

Purpose: ________________________________

Dosage: _________________________________

Side Effects: ____________________________

Is it effectively treating the condition:

____

Medication: ______________________________

Purpose: ________________________________

Dosage: _________________________________

Side Effects: ____________________________

Is it effectively treating the condition:

____

Medication: ______________________________

Purpose: ________________________________

Dosage: _________________________________

Side Effects: ____________________________

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____

Medication: ______________________________

Purpose: ________________________________

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OFFICE POLICIES

1. Cancellation and No-Show Policy

We strive to meet our client's needs for massage by effectively managing our schedule. 24 hour advance notice is required when canceling an appointment, except in cases of illness, emergency or inclement weather.

Cancellations without 24 hour notice will result in a $35 charge for your session, as that time has been set aside specifically for you. The cancellation fee must be paid on the day you notify our office of your need to cancel and must be paid prior to scheduling/receiving your next appointment.

In the event that you fail to show up to your appointment entirely, resulting in a complete loss of time to your therapist, you will be required to pay the full amount for the scheduled session on the day of your missed appointment.

2. Lateness Policy

Our clinic schedules 30 minutes between appointments to accommodate for the time we spend before and after each massage with our clients. Time for your appointment has been arranged especially for you. Please arrive 10-15 minutes early for your appointment as your massage is scheduled to begin at the appointment start time. If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours and full payment will be expected.

3. Permission to Contact You

Your feedback is important to us as it helps us understand your specific needs and how we can better serve you. We are committed to delivering the highest level of care for you which is why we would like your feedback after your initial massage appointment. You will receive an email requesting your review of our clinic to complete at your convenience. This feedback provides us the opportunity to learn more about your overall experience so that we can measure the effectiveness of our therapeutic massage and make modifications, if necessary. In addition, we provide our clients with a monthly newsletter on health tips, reviews of peer providers, and news about the clinic. Please advise us on how you prefer to be contacted by our clinic.

_____ _____
Preferred Email Printed Name

_____ _____
Preferred Contact # Signature & Date

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