Two Roads Massage Therapy LLC

Geri Ruane, LMT #102176

Health History Client Intake Form

Name:_____ Age: _____ Date of Birth:_____

Address:_____City:_____State/Zip:_____

Phone: (Home)_____(cell)_____E-mail:_____

Emergency Contact: (Name/Relationship) _____ (Phone) _____

Areas of stress, pain, or tension:_____ Occupation: _____

Please take a moment to carefully read the following questions. If you have a specific medical condition or specific symptoms, massage may be contraindicated or adjusted to your individual needs. A referral from your physician may be required prior to service being provided.

___Yes___No Have you ever experienced a professional massage? If yes, how often do you receive massage therapy? Weekly/Monthly/Every couple of months? _____

___Yes___No Do you have cancer in your personal history? (If answering yes, complete the Oncology Massage Intake Form)

___Yes___No Have you experienced lymphedema or blood clots? (Circle one or both.) If so, where? _____

__Yes___No Do you have neuropathy in hands/feet?

___Yes___No Do you suffer from headaches/migraines?

___Yes___No Do you have high blood pressure?

___Yes___No Do you have diabetes?

___Yes___No Do you have low blood pressure?

__Yes___No Are you pregnant?

___Yes___No Do you suffer from arthritis?

___Yes___No Are you wearing dentures?

___Yes___No Do you have sensitive skin?

___Yes___No Are you wearing a hearing aid?

___Yes___No Do you suffer from joint swelling?

___Yes___No Are you wearing contact lenses?

___Yes___No Do you currently have a fever?

___Yes___No Do you have varicose veins?

___Yes___No Do you suffer from epilepsy or seizures?

___Yes___No Do you have osteoporosis?

___Yes___No Have you had any broken bones in the past 2 years?

___Yes___No Do you bruise easily?

___Yes___No Do you have spinal problems?

___Yes___No Do you have any allergies? If yes, please explain. _____

___Yes___No Have you been in an accident or suffered any injuries in the past 2 years? If yes, please explain. _____

___Yes___No Do you have any difficulty lying on your stomach, back or side? If yes, please explain. _____

___Yes___No Do you have any allergies to oils, lotions, scents or creams? If yes, please explain. _____

___Yes___No Do you perform any repetitive movement in your work, sports or hobby? If yes, please explain. _____

___Yes___No Are you currently under medical supervision? If yes, please explain. _____

___Yes___No Do you see a chiropractor? If yes, how often? _____

Please list and explain any other medical conditions or give more details about the ones that you marked on page 1 with a "yes":

Please list all medications and their purposes:_____

Which vitamins and supplements do you take? _____

Do you exercise daily or weekly? _____Please explain briefly your type of exercise. _____

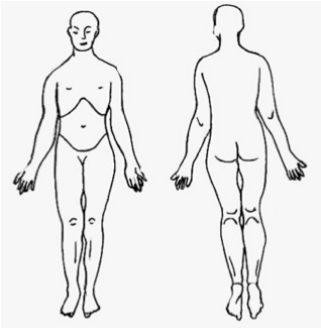
What is your energy level today? from 1-5 (5 being the highest)? _____

Desired pressure: FIRM__MED__LIGHT___ What results would you like from your massage session? _____

Check the areas of your body that you give permission to receive massage:

___ back ___ legs ___ buttocks ___ arms ___ abdomen ___ chest ___ neck ___ head ___ face ___ feet ___ hands

Circle or mark any specific areas you would like me to concentrate on during the session:



Therapeutic breast massage will not be performed. Draping will be used during the session. Clients under the age of 17 must have written consent from a parent or guardian. I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of.

I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly.

I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

_____ _____

Signature of Client Date

_____ _____

Signature of Massage Therapist Date