MOBILITY MASSAGE
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CONFIDENTIAL CLIENT INTAKE AND HEALTH HISTORY FORM

It is important for us to collect an accurate health history to ensure that it is safe for you to receive a massage. All information gathered in this form is confidential except as required or allowed by law. Written authorization will be required for the release of any information. Thank you for your cooperation. We are happy to have you as our client!

SECTION 1: CLIENT INTAKE

Name: _____ Phone Number: _____

Address: _____ Apt/Unit# _____

Buzzer/ Door Code: _____ ☐ House ☐ Townhome ☐ Apartment ☐ Retirement Residence

City: _____ Province: _____ Postal Code: _____

Emergency Contact: _____ Phone #: _____

Date of Birth: DD / MM / YYYY Occupation (OPTIONAL): _____

Email: _____

Would you like to be notified of any promotions Mobility Massage is offering?

☐ Yes, How? ☐ Email ☐ Phone ☐ TXT ☐ No

How did you hear about us? ☐ Facebook ☐ Mobility Massage Vehicles ☐ Poster ☐ Kijiji Ad ☐ Instagram ☐ Google ☐ Referral ☐ Other: _____

Who can we thank for referring you? _____

Why are you seeking massage? _____

Do you have any preferred days or times for your massage? ☐ Mo ☐ Tu ☐ We ☐ Th ☐ Fr ☐ Sa ☐ Su

Time(s): _____

When was your last massage? ☐ Yes, When? _____ ☐ No

SECTION 2: HEALTH HISTORY

In your opinion how is your general health? _____

Are there any Doctors or Medical Professionals you are working with?

DOCTOR/MEDICAL PROFESSIONAL NAME	TYPE OR SPECIALTY	PHONE #:

Are you currently taking any medication? Please list.

NAME OF MEDICATION	PURPOSE

Current Medical Conditions: _____

Allergies/Hypersensitivities: _____

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SECTION 2: HEALTH HISTORY (continued)

Please check the boxes below for any conditions that you are experiencing or have experienced.

SKIN CONDITIONS:

- ☐ Rashes
- ☐ Excessive Dryness
- ☐ Acne
- ☐ Psoriasis/Eczema
- ☐ Athlete's Foot
- ☐ Warts
- ☐ Bruise Easily
- ☐ Open Sores or Wounds
- ☐ Contagious Skin Condition: _____

SOFT TISSUE/BONES/JOINTS:

Please indicate the affected area on the line provided

- ☐ Arthritis ☐ OA ☐ RA ☐ Other: _____
- ☐ Tendonitis ☐ Bursitis _____
- ☐ Weakness _____
- ☐ Sprains ☐ Strains _____
- ☐ Herniated Discs _____
- ☐ Carpal Tunnel Syndrome _____
- ☐ Recent Fracture: _____
- ☐ Recent Surgery: _____
- ☐ Artificial Joints ☐ Pins ☐ Plates

HEADACHES:

- ☐ Tension Headaches
- ☐ Migraines
- ☐ Hydrocephalus
- ☐ Tooth ☐ Jaw ☐ Ear Pain
- ☐ Head Trauma – Date: DD / MM / YYYY

OTHER CONDITIONS:

- ☐ Osteoporosis
- ☐ Epilepsy
- ☐ Cancer: Type _____
- ☐ Diabetes: Type _____
- ☐ Decreased Sensation, where? _____
- ☐ Fibromyalgia
- ☐ Current Fever
- ☐ Swollen Glands

INFECTIONS :

(optional)

- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Other: _____

RESPIRATORY:

- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Sinus Problems
- ☐ Tuberculosis

CARDIOVASCULAR:

- ☐ Phlebitis
- ☐ Deep Vein Thrombosis/Blood Clots
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Stroke ☐ TIA
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Angina
- ☐ Chronic Congestive Heart Failure
- ☐ Heart Murmur
- ☐ PaceMaker
- ☐ High Cholesterol
- ☐ Poor Circulation
- ☐ Cold Hands or Feet

IS THERE ANYTHING ELSE ABOUT YOUR HEALTH HISTORY THAT YOU THINK WOULD BE USEFUL FOR US KNOW ABOUT SO THAT WE MAY PLAN A SAFE AND EFFECTIVE MASSAGE SESSION FOR YOU?

_____

_____

_____

_____

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RELAXATION MASSAGE WAIVER AND CONSENT (PLEASE READ AND SIGN)

I understand that the massage services I receive from Mobility Massage is provided for the sole purpose of comfort, relaxation and stress reduction and is not intended as a treatment for any medical condition(s) or pathology. Because massage should not be performed under certain medical conditions, I affirm that I have answered all questions honestly. I agree to inform my practitioner of any changes in my health and/or medical condition(s). I understand that there will be no liability on the practitioners part should I forget to do so. I understand that the massage practioner has the right to stop the massage at any time due to inappropriate behaviour. I also have the right to stop a massage at any time. If I experience any pain or discomfort during my massage I agree to immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that cancellations with less than 24hrs notice may result in a cancellation charge of $20.00. By signing this release I hereby waive and release the practioner from any and all liability relating to massage or bodywork.

Name of Client (PLEASE PRINT) _____ Date: DD / MM / YYYY

Signature of Client _____ Date: DD / MM / YYYY

Thank you for taking the time to fill out this form with us. We look forward to providing you with the best relaxation massage and...A difference you can feel. Welcome to Mobility Massage!