waha

CONFIDENTIAL CLIENT INTAKE AND MEDICAL HISTORY FORM

Name_____ Phone _____

e-mail_____ Date of Birth_____

How did you hear about Waha?_____ Date of Initial Visit_____

PREFERENCES

1. What is the primary reason for your visit today?

(☐) Relaxation (☐) Pain relief (☐) Sports performance

2. What level of pressure do you prefer?

(☐) Light (☐) Medium (☐) Firm

3. Do you have any objections to any of the following methods?

(☐) Cupping (☐) Muscle scraping (☐) Stretching
(☐) Massage gun (☐) Hot stone (☐) Aromatherapy

LIFE STYLE

4. Do you perform any repetitive movement in your work, sports, or hobby?

If yes, please describe_____

_____

HEALTH

5. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?

If yes, please identify_____

6. Do you have any allergies to oils, lotions, or ointments?

If yes, please explain_____

7. Is there anything about your health history *(injury or surgery)* that you think would be useful to plan a safe and effective massage session for you?_____

_____

8. Please check any condition listed below that applies to you:

(☐) Contagious skin condition (☐) Open sores or wounds (☐) Easy bruising

(☐) Recent accident or injury (☐) Recent fracture (☐) Recent surgery

(☐) Allergies/sensitivity (☐) Artificial joint (☐) Sprains/strains

(☐) Circulatory disorder (☐) Pregnancy

(☐) Joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis

Please explain any condition that you have marked above_____

_____

I,_____(print name) 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 this 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 a 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 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 also understand that any sexual innuendoes or advances will result in immediate termination of service and I will be responsible for payment. 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 have received a copy of the Massage Therapy Policies and Procedures, in which I have read, understand and have had the opportunity to ask questions.

Signature of client_____Date_____