Custom Touch Massage Therapy Intake/Release Form

408-739-4912

Name:_____ Age:_____
Address:_____ Birthdate:_____

City: _____ Wt: _____ Ht. _____

Daytime Phone Number:_____

Email:_____

How did you hear about us?
_____

Cell Phone Number:
_____

In Case of Emergency, please contact:

Name:_____ Phone Number:_____

General Medical Information:

Yes No
- ☐ ☐ Have you ever had a professional massage/bodywork session?
- ☐ ☐ Do you frequently suffer from stress?
- ☐ ☐ Do you experience frequent headaches?
- ☐ ☐ Are you pregnant?
- ☐ ☐ Are you wearing contact lenses?
- ☐ ☐ Are you diabetic?
- ☐ ☐ Do you have high blood pressure? If yes, are you taking medication?
  _____
- ☐ ☐ Are you epileptic?

If you answer YES to any questions in the section below, please write an explaination after the question.

Yes No
- ☐ ☐ Is there a purpose for today's session?

- ☐ ☐ Are you currently under the care of a Chiropractor, Physical Therapist, or any other doctor? Who?
  How Often?

- ☐ ☐ Are you having any discomfort? On a level of 1-10 (1 = minor 10 = extreme), please rate your discomfort.

- ☐ ☐ Is your condition aggravated by certain activities? What type?
  What alleviates your discomfort?

- ☐ ☐ Do you have tension in your body? Where do you feel you hold it?

Yes No
- ☐ ☐ Do you exercise? How often and at what intensity?

- ☐ ☐ Do you drink water during the day? How much?

- ☐ ☐ Are you allergic to any lotions or oils? What kind?

- ☐ ☐ Have you had any injuries in the past 5 years (car accidents, broken bones, etc.)?

- ☐ ☐ Do you have any serious health problems or medical conditions I should be aware of?

Please take a moment and carefully read the following information, and sign where indicated.

I, _____, understand that the massage/bodywork I receive is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

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

Because massage/bodywork is contraindicated (should not be done) under certain medical conditions, I affirm that I have stated all known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioner's part should I forget to do so.

_____ _____

{Client Signature} {Date}

_____ _____

{Massage Therapist Signature} {Date}

Address: 20410 Town Center Lane # 150, Cupertino, CA 95014