Emily Martin, BCST, LMT

Massage Client Intake

Name ________________________________ DOB______________ Phone _____________________

Address__________________________________ Occupation _________________________________

Address__________________________________ Email ______________________________________

Emergency Contact: Name, Relationship ____

Emergency Phone______________________________ Physician_______________________________

Have you received massage before? How long ago? ____

Please describe your current self care: ____

What is your intention or treatment goal? ____

Where do you experience the most discomfort?

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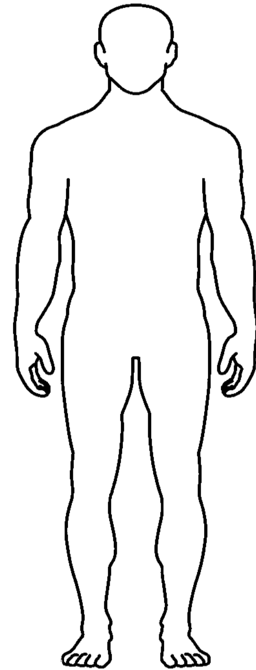

Medical History

A therapist should be aware of existing concerns including high blood pressure, allergies, varicose veins, seizures, cancer, heart conditions, infections/communicable disorders, rashes, lesions or breaks in the skin. Please list these, similar or other applicable medical concerns.

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Accidents & Surgeries

Breaks, sprains and surgeries, major and minor, can leave lasting patterns in the body including restrictions or scar tissue. Please list any you are aware of.

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Did you receive massage, chiropractic, PT or other modalities as part of your healing?

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By signing below I certify that the above information is complete and correct. I will inform the therapist as changes occur if therapy is to be ongoing. I agree to be responsible for all financial obligations for services rendered including no show fee of $25 for appointments not cancelled 24 hours prior. I understand that neither the therapist or the facilities shared/used by the therapist are will be liable for any injuries or loss sustained to myself or property while on the premises. In addition the therapist disclaims responsibility for injury sustained during stretches or excercised that may be suggested. I will not begin excercises or stretches without first consulting my physician.   n

Client Signature_________________________Date_________ Therapist ______________Date_______