LIVE LIFE NOW WELLNESS CENTER L.L.C.

Therapeutic Massage-Client Intake Form

Personal Information:

First Name _____Middle Initial ____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____ Email: _____

Leave Messages on: (Circle one) Home Cell Work Text Don't leave messages

Date of Birth: _____/_____/_____ Gender: Male Female Age:_____

Emergency Contact _____Phone # _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Date of initial visit _____

1. Have you had a professional massage before? Y / N

2. Do you have any difficulty lying on your front, back, side? Y / N

   If yes, please explain _____

3. Do you have any allergies to oils, lotions, or ointments? Y / N

   If yes, please explain _____

4. Do you have sensitive skin? Y / N

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

   If yes, please explain _____

Medical History:

6. Are you currently under medical supervision? Y / N

   If yes, please explain _____

7. Do you see a chiropractor? Y / N If yes how often? _____

8. Are you currently taking any medications? Y / N

   If yes, please explain _____

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

( ) contagious skin condition ( ) phlebitis ( ) open sores or wounds

( ) deep vein thrombosis / blood clots ( ) bruise easily

( ) recent accident or injury ( ) osteoporosis ( ) recent fracture

( ) epilepsy ( ) recent surgery ( ) headaches / migraines

( ) artificial joints ( ) cancer ( ) sprains / strains

( ) diabetes ( ) current fever ( ) decreased sensation

( ) swollen glands ( ) TMJ ( ) back / neck problems

( ) allergies / sensitivity ( ) heart condition ( ) circulatory disorder

( ) Fibromyalgia ( ) high or low blood pressure

( ) tennis elbow ( ) varicose veins ( ) carpal tunnel syndrome

( ) pregnancy ( ) atherosclerosis

( ) joint disorder / rheumatoid / osteoarthritis / tendonitis

Please explain any condition you have marked above _____

_____

_____

10. Is there anything else about your health history that would be useful for the therapist to know in planning a safe and effective massage for you?_____

_____

Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session. An informed written consent must be provided by parent or legal guardian for any client under the age 18.

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 physical or mental ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnosis, prescribe or treat any physical or mental illness, and that nothing said during the course of the session given should be construed as such. Since massage therapy should not be performed with certain medical conditions, I affirm that I have stated all my known medical conditions, answered all question honestly and I have updated the therapist with any changes in my medical profile. I understand that there will not be any liability on the part of the therapist or Live Life Now Wellness Center LLC for any reason. I acknowledge that if I arrive late my session will end at originally scheduled time so the client following me is not penalized. I also understand that any inappropriate remarks or advances made will result in the immediate termination of the session and will be responsible for full payment of your scheduled appointment.

Signature of Client _____Date _____

Signature of Therapist _____Date _____