



# Massage Intake Form

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Emergency Contact Name & Number: \_\_\_\_\_

Check all that apply:

- |   |  |
|---|--|
| <input type="checkbox"/> Knee problems/difficult to kneel | <input type="checkbox"/> Surgery in the last 8 weeks |
| <input type="checkbox"/> Pregnant                         | <input type="checkbox"/> Neuropathy                  |
| <input type="checkbox"/> Cold/flu/infectious disease      | <input type="checkbox"/> Neck/spine injury/problems  |
| <input type="checkbox"/> Seizures/epilepsy                | <input type="checkbox"/> Implanted medical devices   |
| <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Fragile bones/osteoporosis  |
| <input type="checkbox"/> Bruise easily                    | <input type="checkbox"/> Chronic pain condition      |
| <input type="checkbox"/> Varicose veins                   | <input type="checkbox"/> Arthritis                   |
| <input type="checkbox"/> DVT/blood clots                  | <input type="checkbox"/> Tendonitis                  |
| <input type="checkbox"/> Skin condition/rash/open cuts    | <input type="checkbox"/> Heart condition             |
| <input type="checkbox"/> High blood pressure              | <input type="checkbox"/> Fibromyalgia                |
| <input type="checkbox"/> Low blood pressure               | <input type="checkbox"/> Headaches/migraines         |
| <input type="checkbox"/> Cancer/radiation/chemotherapy    | <input type="checkbox"/> Other: _____                |
| <input type="checkbox"/> Lymph nodes removed              | <input type="checkbox"/> Allergies: _____            |

Please list current medications: \_\_\_\_\_

I understand this will be either a seated, fully clothed massage, or a table massage requiring removal of clothing above the waist. I understand that, according to state law, the proper draping techniques will be applied and only the back will be exposed for massage purposes. I understand the benefits and risks of massage and give my consent for treatment. It is also understood that a student in the Therapeutic Massage Program will be giving me my massage. I have stated all my known medical conditions. I understand that the purpose of this massage is to reduce stress and increase relaxation. I will immediately inform the student/instructor massage therapist if I am uncomfortable with the pressure or stroke so it 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 that I should consult a physician, chiropractor or other qualified medical specialist for any mental or physical ailment I am experiencing.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

CONTINUED:

**Minor Informed Consent:**

I hereby give permission to the SPCC Therapeutic Massage Program Student/Instructor to provide my minor child/person under my guardianship with a Therapeutic Massage session.

- I give my consent for my child to receive a fully clothed chair massage.
- I give my consent for my child to receive and/or view a table massage, requiring the removal of clothing above the waist, and being properly draped.

I understand that all statements contained in the consent apply equally to myself and to the minor. By my signature, my child/charge has my permission to appear for a massage session without me present.

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Parent/Guardian Signature

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Date

*Please mail form no later than May 27, 2016, directly to:*

*Kay Hess, Administrative Assistant  
Allied Health and Nursing  
South Piedmont Community College  
P.O. Box 5041  
Monroe, NC 28111*