Serenity Therapeutic Massage
Patient Intake Form

Name_____ Phone_____

Address_____

City/State/Zip_____

DOB:_____

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.

Do you have any difficulty lying on your front, back, or side? Yes/ No
If yes, please explain:
_____

Do you have any allergies to oils, lotions, or ointments? Yes/ No
If yes, please explain:
_____

Any surgery's in the past year?
If so where and what year_____

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes / No
If yes, please explain:
_____

Consent for Treatment
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 that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners 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 the session given should be construed as such. Because massage/bodywork 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 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 fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment**. Understanding all of this, I give my consent to receive care.**

Name_____ Date:_____

Therapist Name _____