5 POINTS MASSAGE

Client Intake Form

Name Phone ( ) DOB

Address City State Zip

E-mail Referred by:

Occupation: Physician:

Emergency Contact: Relation Phone ( )

Clients Gender ☐ Male ☐ Female

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/ bodywork may be contraindicated. A referral from you primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? ☐ Yes ☐ No How recently? _____

What are your massage or bodywork goals? _____

What kind of pressure so you prefer? ☐ Light ☐ Moderate ☐ Firm

If you answer 'yes' to any of the following questions, please explain as clearly as possible.

☐ yes	☐ no	Do you suffer from stress?	☐ yes	☐ no	Do you bruise easily?
☐ yes	☐ no	Do you have Diabetes?	☐ yes	☐ no	Have you broken any bones in the past 2 years?
☐ yes	☐ no	Do you experience frequent headaches?	☐ yes	☐ no	Have you had any other injuries in the past 5 years?
☐ yes	☐ no	If you're a woman are you pregnant?	☐ yes	☐ no	Do you have tension or soreness in a specific area? Please Specify
☐ yes	☐ no	Do you suffer from arthritis?			
☐ yes	☐ no	Are you wearing contact lenses?			
☐ yes	☐ no	Are you wearing dentures?	☐ yes	☐ no	Do you have cardiac or circulatory issues?
☐ yes	☐ no	Do you have a contagious disease?	☐ yes	☐ no	Do you suffer from back pain?
☐ yes	☐ no	Do you have high blood pressure?	☐ yes	☐ no	Do you have numbness or stabbing pains?
☐ yes	☐ no	Are you taking medication for high blood pressure?	☐ yes	☐ no	Are you sensitive to touch or pressure in any specific area?
☐ yes	☐ no	Do you suffer from epilepsy or seizures?	☐ yes	☐ no	Have you **ever** had surgery? Explain below
☐ yes	☐ no	Do you suffer from joint swelling?	☐ yes	☐ no	Do you have any other medical conditions not listed, or are you taking any medications?
☐ yes	☐ no	Do you have varicose veins?	Comments:		
☐ yes	☐ no	Do you have osteoporosis?			
☐ yes	☐ no	Do you have any allergies?			

I understand that Massage, bodywork and somatic therapy practices are designed to promote and maintain the health and well-being of the client. Massage, bodywork and somatic therapies do not include the diagnosis or treatment of illness, disease, impairment or disability. 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. Because massage, bodywork and somatic therapy may be contraindicated due to certain medical conditions, I affirm that I have informed the therapist of all my known medical conditions and will keep the therapist updated as to any changes in my medical condition.

Client Signature **Date**

Therapist Signature **Date**

Consent to Treatment of a Minor: By my signature below, I hereby authorize the employees of 5 Points Wellness dba 5 Points Massage to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent of Guardian _____ Date _____