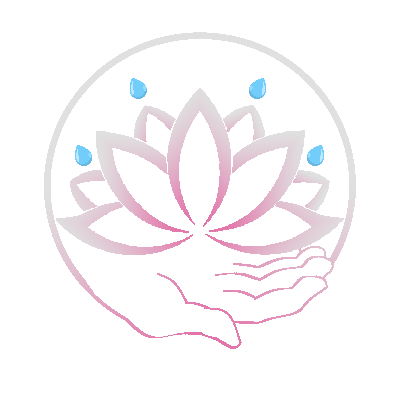
**Tender’s Bodywork & Massage LLC**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Massage and Bodywork Intake Form - Confidential Information

Welcome to Tender’s Bodywork & Massage LLC. We would like to make your appointment as pleasant and as comfortable as possible. If at any time you have any questions regarding your session, we will be happy to answer them.

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | Date of Birth\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ |  |  |
| Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | Home/ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_  Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  |
| Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  |

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name and Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please take a moment to carefully read over the following information and check all that apply. If you have a specific medical condition or specific symptoms, massage/bodywork maybe contraindicated. A referral from your primary care provider maybe required prior to service being provided.

|  |  |  |
| --- | --- | --- |
| Have you ever received a professional massage?  If so, how recently\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes\_\_\_\_ | No\_\_\_\_ |
| Have you ever received energy work? | Yes\_\_\_\_ | No\_\_\_\_ |

If yes, what type and how recently\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the care of a healthcare professional? Yes\_\_\_\_ No\_\_\_\_

If yes, please list names and reason/ treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any medications? Yes\_\_\_\_ No\_\_\_\_

If yes, please list medications and purpose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any current injuries? Yes\_\_\_\_ No\_\_\_\_

Please list any injuries or accidents still affecting you\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Please review this list and mark any conditions that you have currently or that you have | |
| previously had. |  |
| \_\_\_Arthritis \_\_\_Diabetes | \_\_\_Blood Clots \_\_\_Broken Bones |
| \_\_\_DislocatedBones \_\_\_BruiseEasily | \_\_\_Cancer \_\_\_ChronicPain |
| \_\_\_Constipation \_\_\_Diarrhea | \_\_\_Auto-immune Condition \_\_\_Hepatitis |
| \_\_\_Skin Conditions \_\_\_Stroke | \_\_\_Surgery \_\_\_TMJDisorder |
| \_\_\_Depression \_\_\_PanicDisorder | \_\_\_Psych Disorder \_\_\_Diverticulitis |
| \_\_\_Headaches \_\_\_Heart Condition | \_\_\_High Blood Pressure \_\_\_BackProblems |
| \_\_\_Insomnia \_\_\_MuscleStrain | \_\_\_MuscleSprain \_\_\_Pregnancy |
| \_\_\_Scoliosis \_\_\_Seizures | \_\_\_Drug/Alcohol Habit \_\_\_Whiplash |
| \_\_\_AIDS \_\_\_Fibromyalgia | \_\_\_ChronicFatigue \_\_\_Lupus |
| If any of the above needs to be detailed or if there is anything else to share, please do so:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

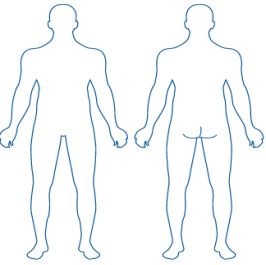
Do you have any of the following today? Please mark all that apply.

|  |  |  |
| --- | --- | --- |
| \_\_\_Skin Rash \_\_\_Cold/Flu | \_\_\_Open Cuts | \_\_\_SeverePain |
| \_\_\_Bruises \_\_\_Injuries  Do you have any allergies to | \_\_\_Anything Contagious |  |
| \_\_\_Foods \_\_\_Nuts | \_\_\_Skin Products |  |

If yes to any of the above, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you wearing: \_\_\_Contact Lenses \_\_\_Hearing Aid \_\_\_Hairpiece

Please indicate with an (x), any of the areas in which you are feeling discomfort:



What are your goals/expectations for this session?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any specific emotional issues that you would like us to focus on today? \_\_\_Yes \_\_\_No

If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Below is a list of normal responses to relaxation during energy and bodywork. We ask that you please allow your body to express whatever it needs to and understand that you are in a safe, secure, non-judging, and confidential environment in which this can take place.

***Sighing, Yawning, Change in breathing, Stomach gurgling, emotional feelings,***

***Emotional expression (including laughing, crying, and anger, Movement of intestinal gas, Energy shifts, falling asleep, memories (sometimes painful***

***ones), Feeling of needing to move or change position, Jerking or shaking of the limbs, and rolling of the head.***

Please read the following information and sign below:

1. I understand that although massage and bodywork can be very therapeutic, relaxing, and reduce muscular tension, it is not a substitute for medical examination, diagnosis, or treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to my medical conditions truthfully.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_