Massage Associates of the New River Valley

2001 South Main Street • Suite 106 • Colony Park • Blacksburg VA 24060
143 Caldwell Lane • Newport, VA 24128 • 540-544-3057 • NRVmassage.com

Client Intake Form

Name: _____ **Telephone: ( )** _____ **Date of Birth:** _____

Email Address (optional): _____

In case of emergency: _____ **Telephone: ( )** _____

General & Medical Information

Occupation: _____ Gender: ❑ male ❑ female

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

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

❑ Yes ❑ No Do you have a Cold or Flu?
❑ Yes ❑ No Do you have asthma ?
❑ Yes ❑ No Do you have any sunburn, poison ivy or rashes?
❑ Yes ❑ No Have you ever been diagnosed with Cancer?
❑ Yes ❑ No Have you had any recent surgeries?
❑ Yes ❑ No Are you having trouble sleeping?
❑ Yes ❑ No Do you have tension or soreness in a specific area?
❑ Yes ❑ No Do you have diabetes?
❑ Yes ❑ No Are you pregnant?
❑ Yes ❑ No Are you wearing contact lenses?
❑ Yes ❑ No Are you taking any medications?
❑ Yes ❑ No Have you ever been in a traffic accident?
❑ Yes ❑ No Have you been in any accident or suffered any injuries in the past 48 hours

Please specify: _____

Comments: _____

_____

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 your primary care provider may be required prior to service being provided.

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. 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 or 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 that I am aware of. I understand that massage/body-work 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.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork or somatic techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____