Massage Intake Form

1. Have you ever had a professional massage before?_____. If so, how often?_____ What style of massage? _____

2. What are the reasons for your visit today?
   □ Relaxation___ □ Tension Relief (site)_____ □ Touch Therapy____ □ Other _____
   □

3. Describe any surgeries you have had:_____
   _____

4. Describe any accidents you have had:
   _____

5. Check all that apply

□ Headache	□ Osteoporosis
□ Stiff/painful joints	□ High/low blood pressure
□ Sleep Problems	□ Scoliosis
□ Neck, shoulder, or arm pain or numbness	□ HIV
□ Fatigue	□ Broken bones
□ Low back, hip or leg pain or numbness	□ Asthma
□ Flu or cold symptoms in the last 48 hours	□ Disc problems
□ Sciatica	□ Thyroid dysfunction
□ Sinus	□ Spasms/cramps
□ Depression	□ Diabetes Y N
□ Allergies to scents , lotions, wool	□ TMJ (jaw pain)
□ Blood clots	□ Currently pregnant
□ Allergies, in general	□ Tendonitis/bursitis
□ Stroke	□ Malignant cancer or tumors
□ Arthritis	□ Benign cancer or tumors
□ Heart disease	□ Spinal Problems
	□ Varicose Veins

6. Describe, as needed, any conditions indicated above, or other conditions that you feel may to be important:
   _____
   _____

7. Are there any areas of your body that are sensitive or that should be avoided?
   _____
   _____

8. Do you exercise? ____ How many times per week? _____ For how long? _____

9. Draping Preferences: □___Full Sheet (max coverage), __Towel(min coverage), □ __Other

10. Music Preferences: □ No music □ Therapist choice □ My own music

11. Pressure Preferences: □ Light □ Light to Medium □ Medium □ Deep

12. I prefer: □ Oil □ Lotion

13. I would like extra focus on: __Upper back ___mid back ___ neck/shoulders __Legs __Hands/feet ___Face

14. **Cancellations:** I understand that all appointments must be canceled within 24 hours. By not doing so, I will be charged the full amount for my missed appointment.
    Signature_____ _____ Date: _____

Health History Form/Waiver

Name: _____ Date:_____

Date of Birth: _____ Sex: M F

Address: _____

Phone: _____ Email:_____

Member e-mails are auto added to an e-newsletter distribution list. Please indicate if you would not like to be added. Add: (circle) Add Do not add

Physician's name and number:_____

How did you hear about KCFITNESSLINK? _____

Person to contact in case of emergency:

Name:_____ Phone:_____ Alt. Phone_____

Are you taking any medications or drugs?

Name of Drug	Dosage	Frequency

Are you taking any over the counter dietary supplements, ergogenic aids or herbal remedies?

Do you now, or have you in the past: **(explain " yes" on back)**	YES	NO
1. History of heart problems, chest pain, or stroke?	☐	☐
2. History of heart problem in immediate family member?	☐	☐
3. Increased blood pressure?	☐	☐
4. Any chronic illness or condition?	☐	☐
5. Difficulty with physical exercise?	☐	☐
6. Advice from physician not to exercise?	☐	☐
7. Recent surgery (last 12 months)?	☐	☐
8. Pregnancy (now or within last 3 months)?	☐	☐
9. History of breathing or lung problems?	☐	☐
10. Muscle, joint, or back disorder, previous injuries?	☐	☐
11. Diabetes or thyroid condition?	☐	☐
12. Cigarette smoking?	☐	☐
13. Increase blood cholesterol?	☐	☐
14. Hernia or any condition that could be aggravated by lifting weights?	☐	☐

Waiver/Release/Refunds

By signing this document, I assume all risk for my health and well being and hold harmless KCFITNESSLNK of any responsibility, the instructor, facility or any persons involved with this program and/or testing procedures. I understand that questions about exercise procedures and recommendations are encouraged and welcomed. I understand there are inherent risks in any physical activity program. I hereby waive, release and forever discharge KCFITNESSLINK and all others from any and all responsibilities or liabilities from injuries or damages resulting from my participation in any physical or therapeutic activities. I do hereby declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity or other illness that would prevent my participation or use of equipment or machinery except as herein stated. I acknowledge that I have been informed that is recommended that I contact my physician and have a physical examination and consultation before beginning a physical activity or therapeutic program. All services and products are non-refundable.

Name: _____ Date:_____