



Massage Therapy
of Fredericksburg

Confidential Massage Client Intake Form – Update

Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Cell phone _____ Home Phone _____
Email: _____ Occupation: _____
Parent/Guardian/ICE: _____ Phone: _____

The following information will be used to plan safe and effective treatments. Please answer the questions to the best of your knowledge.

- What level of pressure is preferred during your sessions:
- Stress Level (1 least – 10 highest)
- What is today's primary concern or goal with your massage
- Do you have difficulty laying on your back, stomach or side?
 - If so, describe what difficulties you experience and in which position(s) you experience it:

- Do you have any allergies? Please list:
- Are you currently under the care of a medical professional?
- Doctor's name and reason for treatment:
- Currently taking any medications?

List name and purpose:

- Are you currently pregnant?
 - How far along?

Massage Therapy of Fredericksburg reserves the right to deny services to anyone in their first trimester or anyone experiencing a high risk pregnancy. Additional consent forms are required.

Have you ever had surgery?

- Please list reason and how long ago

For the following medical conditions, please circle if you have a past history with the illness/injury or are currently experiencing symptoms of the condition:

Autoimmune Condition*	Hernia	Kidney Conditions	Shin Splints
Anxiety	Fever	IBS/Crohn's/UC	Rheumatoid Arthritis
Blood Clots	Fallen Arches	Menopause	Sprain/Strain
Asthma	Easy Bruising	Liver Conditions	Seizures
Bunions	Frozen Shoulder	Implants/Prosthetics	Tendinitis
Broken Bone	Heart Condition	Muscle Spasms	Thoracic Outlet Syndrome
Bladder Infection/UTI	Emphysema	Lyme Disease	Shingles
Bursitis	Headaches	Joint Dislocation	Thyroid Conditions
Carpal Tunnel Syndrome	Herniated Disc	Obstructive Sleep Apnea	TMJ Disorder
Cancer	Fibromyalgia	Multiple Sclerosis	Stroke
COVID-19	Insomnia	Osteoarthritis	Tingling/Numbness
Chronic Fatigue Syndrome	High Blood Pressure	Plantar Fasciitis	Unexplained Swelling
Depression	Hepatitis	Open Sores/Wounds	Varicose Veins
Diabetes	Kyphosis/Lordosis	Osteoporosis	Whiplash
	Infectious Skin Condition	Scoliosis	Warts

*AIDS, Scleroderma, Lupus, etc.

Consent for Treatment

I understand that it is my choice to receive massage therapy. I am aware of the benefits and risks of receiving massage and I hereby give my consent for massage. I understand there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis by a medical professional. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I agree to inform the provider immediately if I feel any pain or discomfort during the session so my provider can adjust the pressure/stokes to my level of comfort. This consent for treatment is valid from the date of signature indefinitely.

Cancellation Policy

As a courtesy, we ask that you please cancel your scheduled appointment with as much notice as possible. Please see our website at www.massagetherapyoffredericksburg.com for our full Cancellation Policy. There are no exceptions to our Late Cancellation and No-Show Policy.

ANY sexual overture will immediately cause a discontinuation of services and possible involvement of local authorities.

By completing this form and submitting it to Massage Therapy of Fredericksburg, I hereby accept and agree to Consent for Treatment, Cancellation Policy and Zero Tolerance Policy.