Bellevue Massage School

Massage Client Intake Form

Personal Information:

Name: _____ Primary Phone: _____
Address: _____
City/State/Zip: _____
Email: _____
Would you like to receive emails about Bellevue Massage School Student Clinic? ___ YES ___ NO
Date of Birth: _____ Occupation: _____
Emergency Contact: _____ Phone: _____

The following information will be used to help plan a safe and effective massage session.

Please answer the questions to the best of your knowledge.

1. How would you rate the current state of your health? Excellent Good Fair Poor
2. Are you currently under a doctor's care? If so, explain: _____
   _____
3. For women, are you pregnant? Yes/No If yes, how far along? _____
4. List other therapies besides conventional medicine in which you are currently participating:
   _____
   _____
5. Are you taking any medication? If so, what? _____
   _____
   _____
6. List previous accidents, surgeries or broken bones:
   _____
   _____
7. Are you experiencing any problems with your body? If so, explain: _____
   _____
8. Where is tension most evident in your body? _____
9. Have you experienced massage before? If so, when? _____
10. Do you have any specific goals for our session? _____
    _____

You need to know that:

1. I am not a doctor.
2. I do not practice medicine.
3. I do not diagnose or treat for a specific illness.
4. I do not prescribe or adjust medication.
5. Massage is not a substitute for medical treatment, but is a complement to most types of therapy.

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Medical History (Please mark past or current conditions):

___ Abscess or open sore
___ Allergies
___ Anemia
___ Anxiety
___ Arthritis
___ Asthma
___ Bursitis
___ Cancer/Malignancy
___ Deep Vein Thrombosis
___ Depression
___ Diabetes
___ Easy bruising
___ Epilepsy
___ Fatigue
___ Fibromyalgia
___ Headaches
___ Heart Problems
___ Herniated disc
___ High Blood Pressure
___ HIV/AIDS
___ Joint Problems
___ Low Blood Pressure
___ Osteoarthritis
___ Osteoporosis
___ Phlebitis
___ PMS/painful menstruation
___ Poor Circulation
___ Pregnancy
___ Rheumatoid arthritis
___ Sciatica
___ Seizures
___ Skin sensitivity
___ Spinal Curvature Problem
___ Stroke
___ Varicose veins

Other_____

I release Bellevue Massage School and ALL Student Practitioners providing student Massage of all liabilities concerning any and all conditions I, myself, may have. I have provided all my known medical information. I acknowledge that manual therapy is not a substitute for medical diagnosis and treatment. I give my consent to receive treatment.

Signature _____ **Date** _____

By signing this form, I give my consent to a Massage Therapy session. I understand that I may discontinue a session or sessions at any time. If I have been diagnosed by a licensed health professional as having any disease, injury or other physical or mental condition, I understand that I should inform the person who made the diagnosis, about the session I will be receiving, and whether or not I intend to discontinue any treatment or therapy which had been previously ordered, prescribed or recommended by a licensed health professional. I understand that by discontinuing any such treatment or therapy, I assume responsibility for any negative outcome resulting from discontinuing that treatment or therapy.

Signature _____ **Date** _____

Records of your reflexology intake and documentation of your session may be released to Bellevue Massage School by your practitioner as part of his/her efforts to be certified. Any information received will be held in the strictest confidence and will not be released outside the school.

I hereby authorize the student practitioner release my health and documentation records as part of the testing process with Bellevue Massage School.

Signature _____ **Date** _____

Print Name _____

MASSAGE IS NOT A SUBSTITUTE FOR MEDICAL CARE. IF YOU ARE EXPERIENCING ANY SPECFIC MEDICAL PROBLEM(S) AND HAVE NOT SEEN YOUR MEDICAL DOCTOR, I RECOMMEND THAT YOU DO SO TODAY.