

**Massage and Reflexology of Delaware
Client Intake Questionnaire**

Name: _____ Date _____

Address: _____ Home Phone: _____ Work _____

Date of Birth: _____

***EMAIL ADDRESS:** _____ **Cell Phone #** _____

(Email addresses will not be used for any other purpose or be distributed or sold to any third party.)

Who may we thank for referring you? _____

Are you under a physician's care? Yes No

If Yes, explain: _____

Have you had any surgery in the last month? Yes No

If Yes, explain: _____

Are you taking any medications? Yes No If yes, list medications and/or conditions associated with medications.

Do you have any allergies? If so, please list _____

Have you ever received a professional massage? Yes No Are you pregnant? Yes No

Please check those that apply

Muscle Tightness or Soreness

Anxiety

Tension

Trouble Sleeping

Headaches

Aching Legs

Restless Legs

Stress

Contagious Disease

Inflammation

Recent Injury

Arthritis

Other _____

Is there a specific body area on which you would like the therapist to concentrate?: (example: shoulders, neck, low back, etc.)

What results would you like to achieve? _____

Have you received any other treatment for your condition? Medication Surgery Physical Therapy

Chiropractic Care None Other _____

I understand that this is a professional massage/reflexology session and is in no way, sexual in nature. If the practitioner feels that **any** inappropriate gestures are made by the client, he/she reserves the right to end the session immediately, with payment due in full.

I understand that Massage and Reflexology are compliments to healthcare and not a substitute for medical supervision of any condition. If I have any medical condition that requires a physician's care, I have consulted him/her regarding receiving a Massage/Reflexology treatment, and either have their consent, or have taken responsibility for the session upon myself. I certify that the above information is correct to the best of my knowledge. I will not hold my massage therapist or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I have disclosed all medical conditions that I am aware of and will inform my massage therapist of any changes in my health status.

Signed: _____

Date: _____

Witness: _____

Date: _____