Unwinding Touch Intake Form
Confidential Information

Name: _____ Date of birth: _____

Address: _____

City, State, Zip: _____

Best phone number: _____ Alternate number: _____

Email address: _____

Emergency contact: _____ Phone number: _____

Have you ever received massage therapy or bodywork? __ Yes __ No

If yes, how recently? _____

Type of massage preferred: _____

What are your massage or bodywork goals? (Check all that apply)

__ Relaxation __ Stress Reduction __ Treatment for specific condition Explain:

_____

_____

What kind of pressure do you prefer? __ Light __ Medium __ Firm __ Not sure

Are you taking medication? _____ If yes, describe: _____

How did you hear about us? _____

Name of person who referred you: _____

What is the best way to remind you of future appointments? __ Phone call __ Text __ E-mail

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.

Do you have a history of the following:

- ☐ Neck pain
- ☐ Whiplash
- ☐ Headaches
- ☐ Spine or disk problems
- ☐ Mid-back pain
- ☐ Low-back pain
- ☐ Joint ache
- ☐ Broken bones
- ☐ Sprains
- ☐ Seizures
- ☐ Decreased range of motion
- ☐ Allergies to oils/perfumes
- ☐ Abdominal pain
- ☐ Nervous tension
- ☐ Osteoporosis
- ☐ Arthritis, bursitis or gout
- ☐ Heart attack/problems
- ☐ Cancer
- ☐ Surgery
- ☐ Fibromyalgia
- ☐ High blood pressure
- ☐ Varicose veins
- ☐ Stroke
- ☐ Aneurysm or epilepsy
- ☐ Colitis
- ☐ HIV positive
- ☐ Lupus
- ☐ Thrombophlebitis
- ☐ Diabetes
- ☐ Chronic Fatigue Syndrome
- ☐ Respiratory problems
- ☐ Hepatitis
- ☐ Numbness
- ☐ Swelling of hands/feet

Other:

(over)

Do you have any of the following today:

□ Sunburn	□ Open cuts, bruises, burns	□ Foot fungus
□ Inflammation	□ Irritated skin rash	□ Excessively tired
□ Severe pain	□ Poison ivy/oak	□ Stress
□ Headache	□ Cold/flu	□ Fever/infection
□ Numbness/tingling	□ Injury	□ Pregnant

Please list any surgeries or major accidents and the year it happened:

_____

_____

_____

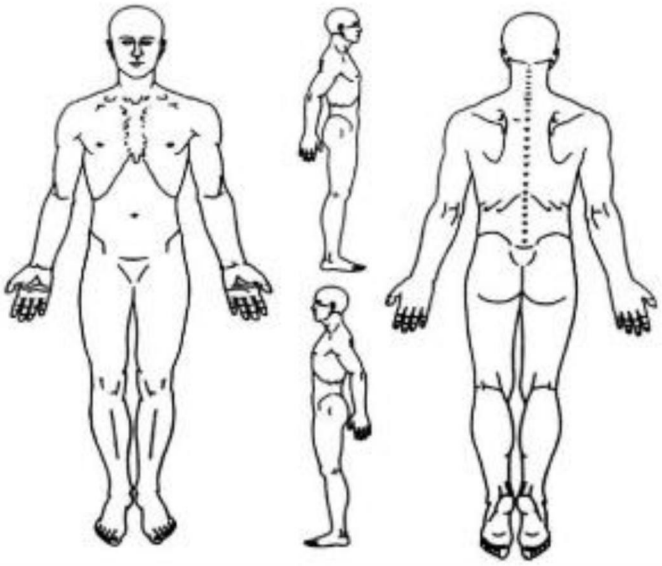
Of special note: (hearing aids, contact lenses, dentures, pacemaker, other special equipment)

_____

Please list any areas of your body you do not wish to be touched (there will be no contact with your breasts or genitals): _____

Any other issues you would like the therapist to be aware of: _____

Please indicate with an ñXò on the picture the places you are feeling discomfort:



Consent for massage and/or bodywork. Please read the following and sign below:

- I understand that this massage is not a replacement for medical care and that no diagnosis will be made. It is recommended a physician be seen for any ailment I might have.
- I am responsible for paying for any appointment cancellations of less than 24 hours.
- I will disrobe to my comfort level. If at any time I am uncomfortable with the pressure or technique being used, I can ask the practitioner to make the necessary adjustment or stop the treatment.
- I understand that this is a nonsexual therapeutic massage.
- I understand that massage/bodywork should not be performed under certain medical conditions and I affirm that I have stated all of my known medical conditions. I agree to keep the practitioner updated as to any changes in my health and medications and understand that there shall be no liability on the practitioners part should I fail to do so.

Signature: _____ Date: _____

Your privacy and confidentiality are respected and valued. Neither your information nor treatment will be discussed without your prior written consent.