Heart Song Mental Health Counseling & Massage Therapy, PLLC

Marian Bauman-O'Dell, LMHC, CASAC, LMT

Massage Intake Form

Name_____

Address_____

Street / PO Box City State Zip

Contact Information	Permission to Contact or Leave A Discreet Message?
Home: _____	____yes ____no _____initials
Work: _____	____yes ____no _____initials
Cell: _____	____yes ____no _____initials
Email: _____	____yes ____no _____initials

Date of Birth:_____ Age:_____ Marital Status: _____

Employer: _____ Occupation: _____

Emergency Contact:_____

Name / Relationship/Phone (including area code)

Name of Primary Care Provider_____

Are you currently being treated for any conditions? _____Yes _____No

If yes to the above – what conditions are you being treated for and for how long?

_____

Are you taking any medications? _____Yes _____No

If yes to the above - what medication, dosage and for how long?

_____

_____

Referred by_____

Reason for treatment today: Relaxation_____ Stress_____ Injury/Pain_____ Other_____

Have you ever experienced a professional massage or bodywork session? _____Yes _____ No

If yes, when was your last massage? _____How often do you receive massage? _____

What type of pressure do you prefer? _____Light _____Medium _____Firm _____Deep ($10 additional)

Please take a minute to carefully read the following information. If you have a specific medical condition or specific symptom(s), massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Please circle any of the following conditions that you may have or have had **within the past year**.

Arthritis	Fainting Spells	Asthma	Vertigo	Bursitis
Skin Disorder	Sciatica	Edema	Sinusitis	Insomnia
Stomach Disorder	Headaches	Diabetes	Blood Clots	Dizziness
Heart Condition	TMJ	Claustrophobia	Fibromyalgia	Neck Pain
High/Low Blood Pressure	Herniated Disc	Chest Pain	Cold/Numb Feet or Hands	

If you circled yes to any of these conditions, please explain: _____

_____

Are you pregnant or nursing? _____ Do you wear contact lenses? _____ Do you wear dentures? _____

Do you have a pacemaker? _____ How much water do you drink a day? (# of glasses) _____

Do you exercise regularly? _____ Are you sensitive to any lotions or oils? _____

How would you describe your overall level of stress? Low _____ Medium _____ High _____

Do you have limited range of motion? Describe _____

Agreement: I understand that the treatment I receive is provided for the purpose of relaxation and relief of muscular tension. If I experience any discomfort during this session, I will inform the practitioner so that the pressure and//or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustment, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so . It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for full payment of scheduled appointment.

CANCELLATION POLICY: I acknowledge that failure to provide 24 hours notice of cancellation (except in special circumstances which are considered on an individual basis) will result in a cancellation fee equal to the massage therapy fee and payable prior to additional massage visits.

Print Name:_____

Signature:_____ Date:_____/_____/_____

Consent to Treatment of a Minor

By my signature below, I hereby authorize Marian Bauman-)'Dell to administer massage, bodywork or somatic therapy techniques to my child or dependent as they deem necessary. All treatment and conditions have been reviewed and discussed as needed by me, the practitioner, and the dependent.

Signature of Parent or Guardian _____