# Client Care Profile

**Please Print Clearly**

**Name:** ____________________________ **Date of Birth:**___________________ **Occupation**:__________________________

**Address:** ________________________________________ **City:** __________________________ **Zip Code:** ____________

**Phone 1: (____)** ________________ ☐ **Home** ☐ **Cell** ☐ **Work** **Phone 2: (____)** _________________ ☐ **Home** ☐ **Cell** ☐ **Work**

**E-mail address:** ________________________________ **Referred by:** __________________________________

General & Medical Information

Have you ever experienced a professional massage or bodywork session? ☐ Yes ☐ No How recently? ________________

What type of massage do you prefer? ☐ Light Touch ☐ Firm Touch ☐ Other __________________________________

Age: ________ ☐ Female ☐ Male Ladies Only: Are you pregnant? ☐ Yes ☐ No Due Date:________________

In case of emergency: ______________________________ Phone: (____) _______________

**Please 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 massage/bodywork.**

| | Yes | No |
|---|---|---|
| Do you frequently suffer from stress? | ❒ | ❒ |
| Do you have any allergies? (especially fragrances or oils) | ❒ | ❒ |
| Do you bruise easily? | ❒ | ❒ |
| Do you have varicose veins? | ❒ | ❒ |
| Do you have osteoporosis? | ❒ | ❒ |
| Have you been in an accident or suffered any injuries in the past two years? | ❒ | ❒ |
| Do you have cardiac or circulatory problems? | ❒ | ❒ |
| Do you have diabetes? | ❒ | ❒ |
| Is there any part of your body you do not want touched? | ❒ | ❒ |
| Do you have high blood pressure? Please state the medication you are taking for this: ________________________ | ❒ | ❒ |

| | Yes | No |
|---|---|---|
| Have you ever had surgery? | ❒ | ❒ |
| Do you suffer from epilepsy or seizures? | ❒ | ❒ |
| Do you have any numbness or stabbing pains? | ❒ | ❒ |
| Do you experience frequent headaches? | ❒ | ❒ |
| Are you very sensitive to touch or pressure in any area? | ❒ | ❒ |
| Do you have any broken skin (i.e. rashes or wounds)? | ❒ | ❒ |
| Do you have any old injuries I should know about? | ❒ | ❒ |
| Do you have any fungus on your feet or nails? | ❒ | ❒ |
| Do you have any other medical condition or are you taking any medications I should know about? | ❒ | ❒ |

Where in your body do you hold tension? ____________________________________________________________

**If you answered "yes" to any of the above questions, please explain as clearly as possible.**
Comments: ______________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**What is/are your main goal(s) for the session today, and long term?**

______________________________________________________________________________

______________________________________________________________________________

Signature:____________________________________________ Date:____________________

*(over)*

**Consent to Treatment of Minor:** By my signature below, I hereby authorize ___________________________ to administer massage, bodywork or somatic therapy techniques to my child or dependent as they deem necessary.
**Signature of Parent or Guardian: ____________________________________ Date:______________**

**Disclosures**

I understand that the massage/bodywork I receive is provided for the basic purpose of relation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/ bodywork, practitioners are not qualified to perform spinal or skeletal adjustments, 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 fail to do so. I also understand 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 payment of the scheduled appointment.

**Client Initials ____________**

**Cancellation Policy**

12 hours notice is required for all cancellations. There is a cancellation fee equal to 50% of scheduled service for appointments canceled with less than 12 hours notice.

**Client Initials ____________**

**Late Policy**

If client is late, therapist will do his /her best to accommodate. However, in the event another appointment is scheduled immediately after, client will receive the scheduled time remaining, and will be responsible for payment of the full session amount. If the therapist is late, the client will receive the full scheduled time, or the remaining scheduled time will be pro-rated.

**Client Initials ____________**

**Returned Check Policy**

If a check is returned unpaid for insufficient funds, a fee of $25 will be charged to the client.

**Client Initials ____________**

**Privacy Policy**

Client understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. If you would like to have more detailed information about our policies and procedures concerning the privacy of your information, we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone that you do not want to receive your medical records, please inform our office. In the event the client is visiting any of the practitioners listed below, client initials indicate permission for those practitioners to discuss any and all pertinent health issues amongst themselves to the benefit of the client. This office does not release client information to any third parties.

Crane Massage Therapy sends, from time to time, email and postal mail notices of seasonal and special promotions. If you would prefer NOT to receive any such notices, please check here: ❐

List Permissible Practitioners (i.e. Personal Trainer, Physical Therapist, Chiropractor, Supervising MD, etc., or "Any"):

______________________________________________________________________________

**Client Initials ____________**

# Pregnancy Massage Client Intake Form Supplement

Name ______________________________________________________

Do you exercise? _____ How many times per week? _____ For how long? ________________________

Have you had any serious or chronic illness, operations, or traumatic accidents? ____________; If yes, please explain:
____________________________________________________________________________________________________

____________________________________________________________________________________________________

**Prenatal Care Doctor/Nurse-Midwife/Midwife____________________________ Telephone ____________________**

**May I have permission to contact this Care Provider? _____________**

**Due date: _______________________**

**This is your _________( 1st, 2nd, etc.) pregnancy. This will be your ______ ( 1st, 2nd, etc.) birth.**

**You are _______(number) weeks pregnant in your ________ (1st, 2nd, 3rd) trimester.**

Please check (√ ) current problems, mark with (+) if you had in the past :

___anemia
___leaking amniotic fluid*
___bladder infection*
___uterine bleeding*
___blood clot or phlebitis*
___chronic hypertension*
___abdominal cramping*
___diabetes (gestational or mellitus)
___edema/swelling
___fatigue
___headaches
___insomnia
___high blood pressure*
___leg cramps
___miscarriage*
___nausea
___problems with placenta*
___pre-term labor*
___Braxton-Hicks contractions*
___preeclampsia (toxemia)*
___sciatica
___separation of the rectus muscles
___separation of the symphysis pubis
___skin disorders/ athletes foot
___twins or more!*
___varicose veins
___visual disturbances*
___previous cesarean birth
___contagious conditions
___muscle sprain / strain
___heart attack / stroke
___arthritis
___carpal tunnel syndrome
___allergy to nut oils
___low blood pressure
___bursitis
___hypo or hyperglycemia
___contact lenses
___ Other conditions or problems in current or past pregnancy:__________________________________________________

____________________________________________________________________________________________________

Anything else you would like me to know?____________________________________________________________
________________________________________________________________________________

I am experiencing a low risk / high risk (circle one) pregnancy according to my doctor/midwife. If I am currently having or develop complications (any conditions/symptoms listed above with *) I will discuss the condition with my massage therapist, and will have a medical release for bodywork signed by my prenatal care provider before continuing bodywork.

I have completed this health form to the best of my knowledge. I understand that Bodywork is a health aid and does not take the place of a physician's care. Any information exchanged during a Massage or Bodywork session is confidential and is only used to provide you with the best health care services.

If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance. If I miss a scheduled appointment without giving 24 hours' notice, I agree pay any missed appointment charge.

I am responsible to pay for any Massage or Bodywork fees not paid for by my insurance company.

Name (signature)__________________________________________ Date:______________________