

Client Intake Form

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Name _____ Phone _____ Date of Birth _____
Address _____
City/State/Zip _____
Email _____ Occupation _____
Physician/Care Provider _____
Emergency Contact _____ Phone _____
Were you referred by anyone? _____

Date of initial visit _____

1. Is there a particular area of the body where you are experiencing tension, stiffness, pain, or discomfort? Is it chronic or acute?

2. Do you have any particular goals in mind for this massage session?

3. What type of pressure do you prefer?

Light Medium Firm/Deep Unsure

4. Please list any current or past injuries and surgeries _____

5. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you (pregnancy/chronic conditions/medications/etc)?

I have answered the above questions to the best of my knowledge and agree to inform the practitioner if any information/health conditions change. I understand that massage therapy is not a substitute for medical care, and my massage therapist does not diagnose or treat illness. I understand it is my responsibility to communicate with my therapist if I have concerns or questions about my session. I do not have any injuries or conditions that would prevent me from receiving massage, nor have I been told by a health care provider that I should not receive massage. I will not hold my massage therapist liable in the unlikely event of injury. I understand there is a 24 hr cancellation policy otherwise payment in full is required (waived in case of emergency).

Client (or Guardian) Signature _____ Date _____

Massage Therapist Signature _____ Date _____