

Initial Visit Intake Form

Brock's Therapeutic Massage, LLC

All information is kept confidential

Name _____

Primary Phone Number (cell or land) _____

Secondary Phone Number (cell or land) _____

Email _____

Address _____

City, State, Zip _____

Emergency contact (name and phone number) _____

Occupation _____

Referred by _____

Birthday (mm/dd/year) _____

Potential contraindications?

_____ Heart condition/blood clots/strokes

_____ Varicose Veins

_____ Broken Bones

_____ Recent Surgeries

_____ Brain Injuries

_____ HIV/AIDS

_____ Contagious Conditions _____

_____ Pregnancy

Medications _____

Are you seeking treatment for an auto accident? _____

Describe your physical activity, sports, exercise, yoga, etc. _____

Do you have any allergies (especially those found in lotions) _____

What are your health goals? How do you see massage helping? _____

I understand that the massage/bodywork I receive is provided for the basic purpose of muscular tension release and/or relaxation. I understand that the massage or bodywork should not be construed as a substitute for medical examination, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any ailment that I am aware of. I understand that it is my responsibility as a client to communicate with the massage therapist any discomfort that occurs during the session. I also understand that it is my responsibility to communicate any updates regarding changes with my health. I understand that there shall be no liability on the therapists part should I fail to communicate. Also, I understand that any sexually suggestive remarks or advances are unacceptable and will not be tolerated. I understand that it is my responsibility to notify the therapist at least 24 hours in advance in the event that an appointment needs to be cancelled or rescheduled, and if I fail to do so, or miss the appointment, I accept the responsibility for payment of the scheduled session.

Signed _____ Date _____