



HIGH PERFORMANCE MASSAGE

Subjective Intake

General Personal Questions:

Location, Structure, & Classification: _____ Date: 20 ____ - ____ - ____

Name: _____

Company: _____ Job Title: _____

Email: _____ Website: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Work Phone: (____) _____ - _____ Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Work Address: _____ City: _____ State: _____ Zip Code: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Relationship: _____ Phone: (____) _____ - _____

Date of Birth: ____-____-____ Gender: _____ Height: ____'-____" Weight: _____

Do you presently have a Contagious Condition / Fever / Are you Intoxicated?-----Yes / No

Have you ever had a professional massage before? Yes / No Where? _____

What is your reason for seeking Massage Therapy: _____

What goal would you like from Massage Therapy: _____

What type of pressure do you think you would enjoy (1 = light ⇒ 5 = heavy pressure)? _____

Where would you rate your mental/emotional stress level (1 =little ⇒ 5 extreme stress)? _____

What do you think is the source of your stress? _____ Where do you carry your stress? _____

Do you have a music preference? Ambient / Classical / Organic / Acoustic / Reggae / Jazz / Lite Rock / None / Other: _____

Do you sleep on your (circle all that apply): back / left side / right side / front - Arm & Leg position: _____

Are you? -----Right-handed / Left-handed

Do you clench your teeth? -----Yes / No

Do you stretch regularly? -----Yes / No

Do you think that you're well hydrated? -----Yes / No

Do you smoke? Yes / No How long? _____ Combining Alcohol & Caffeine, Describe Intake? Heavy / Medium / Light

Besides genitalia & breast tissue, is there any area of your body you prefer left unattended? _____

Would you enjoy Aromatherapy?----- Relaxation / Stress Relief / Clear Mind / Sweet Orange / Eucalyptus / Lavender / None / Open



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Medical Questions:

Could you be pregnant? Yes / No -----Due date: _____ - _____ - _____

Do you have any allergies, specifically topical? Yes / No

Do you lose your balance because of dizziness or do you ever lose consciousness? -----Current / Past / Never

Do you experience frequent &/or intense headaches? -----Current / Past / Never

Describe: _____

Do you, or have you ever had conditions affecting the following body systems:

Skin: Contagious Conditions / Burns / Wounds / Rashes / Warts / Infections _____ Current / Past / Never

Skeletal-Joint: Osteoporosis / Arthritis / Scoliosis / Spinal Disc Problems _____ Current / Past / Never

Cardiac/Circulatory: Heart Problems / Blood Clots / Stroke / High or Low Blood Pressure / Varicose Veins / Poor Circulation
_____ Current / Past / Never

Endocrine: Diabetes / Hyper-Thyroid / Hypo-Thyroid _____ Current / Past / Never

Respiratory: Asthma / Emphysema / Bronchitis / Other COPD _____ Current / Past / Never

Digestive & Urinary: Abdominal Pain / Bowel Dysfunction / Gastric Reflux / Bladder Problems / Kidney Dysfunction _____ Current / Past / Never

Do you bruise easily?-----Yes / No Do you experience edema (swelling)? _____ Current / Past / Never

Please list & date any major illness / surgery / accident / fracture / strain: _____

Outcome: _____

Please list all medications you currently take & the condition the medication is treating: _____

Occupational Questions:

What is your current occupation? _____

Does your occupation require extended periods of: Sitting / Standing / Walking / Running / Lifting / _____

Does your occupation require any repetitive movements? _____ Yes / No

Does your occupation require you to wear shoes with a heel (dress shoes)? -----Yes / No

Recreational Questions:

Do you partake in any sports or game recreational activities? Hiking / Golf / Tennis / Skiing / Basketball / Soccer / Football / Hockey / Skiing

Other _____

Frequency & Duration: _____

Do you have any hobbies? Reading / Computers-Internet / Gardening / Automotive / Dancing / Other _____

Frequency & Duration: _____

Do you participate in any exercise activities? Weight Resistance Training / Running / Biking / Swimming / Other _____

Frequency & Duration: _____



HIGH PERFORMANCE MASSAGE

Front

Back

Front

Back



Right

Left

Right

Left

Right

Please illustrate any area to describe what you might be feeling.

Agreement:

I understand that the massage/body-work I receive is intended for the purposes of increased circulation, relaxation, & relief of soft tissue tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure &/or techniques may be adjusted to my level of comfort. I further understand that massage/body-work should not be construed as a substitute for medical examination, diagnosis, or treatment & that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/body-work practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, & that nothing said in the course of the session given should be construed as such. Because massage/body-work should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions & answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile & understand that there shall be no liability on the practitioners 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, & I will be liable for payment of the scheduled appointment. Additionally, I understand that High Performance Massage is separate from and unaffiliated with any Lifestart Wellness Center. I agree to waive all claims against Lifestart, their officers, and affiliates based on any act or omission of High Performance Massage, its agents, or employees.

Client Signature: _____ Date: _____

Printed Name: _____

Therapist Signature: _____ Date: _____