azima therapeutic massage

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**GENERAL HEALTH HISTORY INTAKE**

Name: _____ Date: _____

Address: _____

City/State/Zip: _____

Phone: (____) _____ Email: _____

May we add you to our e-mail list to receive occasional announcements about promotions and updates? **Yes** **No**

Date of Birth: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

How did you hear about Azima Therapeutic Massage? _____

Please describe the reason for your visit today: _____

_____

Are you taking any medications? **Yes** **No**
If yes, please list: _____

Are you pregnant? **Yes** **No** Due Date: _____

Are you currently undergoing cancer treatment or have you ever been treated for cancer? **Yes** **No**
**If yes, please complete the Oncology Massage Intake Form**

Have you had a professional massage before? **Yes** **No**

If yes, was there anything you particularly liked or disliked about your past massage treatments? _____

_____

Are you experiencing excessive or unexpected stress in your work, family, or other aspect of your life? **Yes** **No**

If yes, please explain: _____

Please check any condition listed below that applies to you:

| | | | |
|---|---|---|---|
| ( ) contagious skin condition | ( ) phlebitis | ( ) allergies to oils or perfume | ( ) broken bones |
| ( ) open sores or wounds | ( ) deep vein thrombosis/blood clots | ( ) high/low blood pressure | ( ) heart condition |
| ( ) easy bruising | ( ) arthritis/bursitis | ( ) circulatory disorder | ( ) HIV |
| ( ) recent accident or injury | ( ) osteoporosis | ( ) varicose veins | ( ) scoliosis |
| ( ) recent surgery | ( ) epilepsy | ( ) TMJ | ( ) tumors, cysts |
| ( ) artificial joint | ( ) headaches/migraines | ( ) carpal tunnel syndrome | ( ) whiplash |
| ( ) sprains/strains | ( ) diabetes | ( ) tennis elbow | |
| ( ) current fever | ( ) fibromyalgia | ( ) neuropathy/numbness/tingling | |
| ( ) swollen glands | ( ) back/neck problems | ( ) contact lenses | |

Is there anything else about your health history that you think would be useful for your massage practitioner to know in order to plan a safe and effective massage session for you? _____

_____

I affirm that I have stated all my known medical condition and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension.

I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment, or pharmaceuticals, nor does the therapist perform any spinal manipulations.

I understand that I have the right to terminate a massage therapy session at any time should I feel that the treatment I am receiving is inappropriate and/or not fulfilling the treatment goals set by myself and the massage therapist.

I understand that any inappropriate behavior on my part will lead to the immediate termination of my treatment by my massage therapist, and that payment for the full session will be required.

I understand that when I make an appointment, that time is reserved exclusively for me. I will remit payment for any appointments not cancelled at least 24 hours in advance (baring illness or emergency.)

I have read and understand the above conditions and policies.

_____

(Signed)

_____

(Dated)