

# Better Bodies Atlanta Massage

## Client Intake Form

### Personal Information

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

### Massage Information

Have you ever had a professional massage before? \_\_\_ Yes \_\_\_ No

If so, how often do you receive massage therapy? \_\_\_\_\_

What are your intentions or expectations for this visit? Please specify any symptoms or areas you would like the massage therapist to focus on during the session?

\_\_\_\_\_

What are your common areas of pain or tension? \_\_\_\_\_

What is your current occupation? \_\_\_\_\_

Does it involve long periods of any of the following? \_\_\_ Sitting \_\_\_ Standing

\_\_\_ Computer Work \_\_\_ Telephone Work

Do you have a pressure preference? \_\_\_ Light \_\_\_ Medium \_\_\_ Deep

Do you have sensitive skin?  Yes  No

Do you wear contact lenses?  Yes  No

Do you exercise regularly? \_\_\_  Yes  No

If so, what type(s)? \_\_\_\_\_

Are you currently taking any prescription medication? \_\_\_ yes \_\_\_ no

If yes, for what condition? \_\_\_\_\_

Please specify any known allergies. \_\_\_\_\_

### Pregnant Clients Only (Otherwise please skip ahead to Health History.)

When is your expected Due Date? \_\_\_\_\_

Number of Pregnancies: \_\_\_\_\_ Number of births: \_\_\_\_\_

Is this your first Prenatal Massage? \_\_\_ Yes \_\_\_ No, my last was: \_\_\_\_\_

Are you having a high-risk pregnancy? \_\_\_ Yes \_\_\_ No

If yes, please explain: \_\_\_\_\_

Please indicate any of the following that you have or had during your pregnancy.

- |   |   |
|---|---|
| <input type="checkbox"/> Headaches                  | <input type="checkbox"/> Edema          |
| <input type="checkbox"/> Sinus congestion           | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Morning sickness or nausea | <input type="checkbox"/> Hemorrhoids    |
| <input type="checkbox"/> Heartburn                  | <input type="checkbox"/> Constipation   |
| <input type="checkbox"/> High Blood pressure        | <input type="checkbox"/> Diarrhea       |
| <input type="checkbox"/> Low Blood Pressure         | <input type="checkbox"/> Pre-Term Labor |
| <input type="checkbox"/> Thyroid Problems           |   |

### Health History

Please indicate any conditions that apply to you, past and present.

#### Musculo-Skeletal

- Headaches
- Joint Stiffness/  
Swelling
- Spasms/ Cramps
- Broken/ Fractured  
Bones
- Sprains/ Strains
- Back/ Hip Pain
- Shoulder, Neck,  
Arm, Hand Pain
- Leg/ Foot Pain
- Chest, Ribs,  
Abdominal Pain
- Problems Walking
- TMJ/Jaw Pain
- Tendonitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone or Joint  
Disease
- Other: \_\_\_\_\_

#### Circulatory/ Respiratory

- Cold Hands or Feet
- Swollen Ankles
- Varicose Veins
- Blood Clots
- Stroke
- Heart Condition
- Allergies
- Sinus Problems
- Asthma
- High Blood Pressure
- Low blood Pressure
- Lymphedema

#### Skin

- Rashes
- Allergies
- Athlete's Foot
- Warts
- Moles
- Acne
- Cosmetic Surgery
- Other: \_\_\_\_\_

#### Digestive

- Nervous Stomach
- Indigestion
- Constipation
- Intestinal Gas/  
Bloating
- Diarrhea
- Diverticulitis
- Irritable Bowel  
Syndrome
- Crohn's Disease
- Colitis
- Adaptive Aids
- Other: \_\_\_\_\_

#### Nervous system

- Numbing/ Tingling
- Twitching of Face
- Fatigue
- Chronic Pain
- Sleep Disorders
- Ulcers
- Paralysis
- Herpes/ Shingles
- Cerebral Palsy

- Epilepsy
- Chronic Fatigue Syndrome
- Muscular Dystrophy
- Spinal Cord Injury

**Reproductive System**

- Pregnancy
- PMS
- Menopause
- Pelvic Inflammatory Disease
- Endometriosis
- Hysterectomy
- Fertility Concerns
- Prostrate Problems

**Other**

- Loss of Appetite
- Forgetfulness
- Confusion
- Depression
- Difficulty concentrating
- Nicotine Use
- Caffeine Use
- Hearing Impaired
- Visually Impaired
- Diabetes
- Fibromyalgia
- Cancer
- Infectious Disease (please list)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Surgeries: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any additional comments regarding your health and well-being.

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## Massage Policies

**24 Cancellation Policy-** Kindly give us 24 hours to cancel or reschedule an or a 50% charge of the original price will incur.

**Late Arrival Policy-** If the client arrives late they will receive the remaining time from their original session at the original price.

**Ethics Policy-** Therapeutic massage is strictly non-sexual. If client expresses interest in sexual massage, the therapist will terminate the massage immediately and payment for appointed service will be rendered in full.

**Privacy Policy-** All written records and massage sessions are kept strictly confidential and will not be shared with any outside establishment, individuals, organizations, or medical facilities without explicit written consent from the client (you) or the client's legal guardian. Unless legally required by local, state, or federal subpoena, summons, or other court order.

## Massage Therapy Informed Consent

I understand that massage therapy provided by Henriette Steffensen is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch.

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that massage therapy does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

I understand the therapist's policies and agree to abide by them.

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Client's Signature

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Date