Diedra I Eshcoff, CMT

3530 Stellhorn Rd.
Fort Wayne, In 46815
260-715-3388

Intake form for Therapeutic Massage and Client Informed Consent

Welcome! I am looking forward to making your appointment as pleasant as possible. By completing this form you are helping me to learn how I can help you. If you have questions regarding your session, please let me know. My intension is you facilitate relaxation, relieve muscle tension and pain without causing harm.

Name: _____ Date of Birth: _____ M/F Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____
Phone(s) _____ Emergency Contact and Ph: _____
Have you ever received Massage Therapy? If so, how long ago? _____
What is your Occupation? _____
Do you play sports? If so, please list. _____
_____
Do you exercise regularly? _____

If you answer "yes" to any of the following question, please explain as clearly as possible:

□Yes □No Are your stress levels High?
□Yes □No Are you Diabetic?
□Yes □No Do you have headaches frequently?
□Yes □No Are you pregnant?
□Yes □No Do you have arthritis?
□Yes □No Are you wearing contacts?
□Yes □No Do you have high blood pressure
□Yes □No Do you have epilepsy or seizures?
□Yes □No Do you have swelling in your joints?
□Yes □No Do you have varicose veins?
□Yes □No Do you have any contagious diseases?
□Yes □No Do you have osteoporosis?
□Yes □No Do you have allergies?
□Yes □No Have you ever had cancer? If so, answer the following:

- Type of Cancer?_____(Active or Remission)
- Where is/was your Cancer?_____
- Were Lymph Nodes removed? _____ How many? _____
- Treatment Type?_____
- _____
- _____

_____
_____
_____
_____
_____

□Yes □No Do you bruise easily?
□Yes □No In the past 2years have you had any broken bones?
□Yes □No In the past 2years have you had any injuries?
□Yes □No Do you carry your tension or soreness in any specific areas?
Please describe: _____
_____
□Yes □No Do you have cardiac or circulatory issues?
□Yes □No Do you have frequent back pain? _____
□Yes □No Do you ever experience stabbing pain or numbness?
□Yes □No Do you have any areas sensitive to pressure?
□Yes □No Have you ever had surgery? Explain: _____
□Yes □No Are you taking medications or have other conditions I should know about? _____

I have to the best of my knowledge completed this form. I will let the massage therapist know when my personal health changes in any way. I realize that a massage therapist cannot prescribe medication, diagnose any conditions or illnesses, or do any spinal manipulations. It is my responsibility to consult with a qualified physician for any physical ailments that I have. Massage therapy is therapeutic and intended to be non-sexual. If I make any sexual advances the session will be terminated and charged the full rate. If I am late for an appointment I will be charged the same rate as a full session. If the therapist is late my session will be extended if possible or my rate will be reduced. I will give 24 hour notice if my session needs to be canceled or I will be charged the full rate. If I am a minor parental consent will need to be given prior to the session.

_____ _____ _____
Client Signature or Parent Signature Massage Therapist Signature Date