Fingers of Light

HEALTH INTAKE

Personal Information

Name ___________________________________ Date of Birth ____
Address __________________________________ Email ____
Occupation
____
____ Phone (primary) ___________________________
Emergency Contact __________________________________ (secondary) _________________________
Contact's Phone _____________________________________
How did you hear about Fingers of Light?
____

Health History

Please list all serious injury, past and current: ____
____
Please list any and all surgeries: ____
____
Please list all allergies: ____
Please list any skin problems pertaining to face or body: ____
Please list any medications and their use: ____

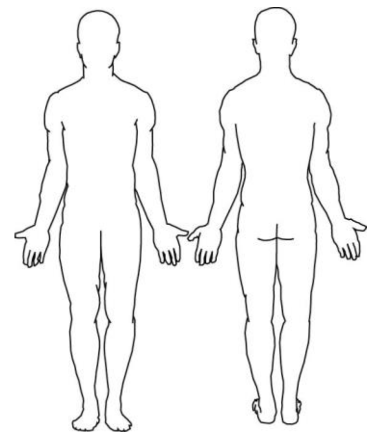
Contraindications for massage. I can perform massage with your doctor's permission and/or instruction if any of the following conditions are either acute or chronic. Please check all that apply currently.

____Fever
____Tumors/Cancer
____Contagious Diseases
____Recent Operations/Acute Injury
____Swelling/Inflammation (Gout, RA, Diabetes, Lymphedema, etc.)
____Skin Damage/Infection/Burns
____Nerve Damage (Neuritis, Bell's Palsy, Parkinson's, etc.)
____Bleeding Disorders (clots, hemophilia, etc.)

Conditions for special consideration for massage. Please check all, past or current, which apply to you:

____Fibromyalgia
____Heart Disease
____Disc Herniation
____Digestive Conditions
____Skeletal Injury/ Dysfunction
____Psoriasis
____Metal Implants
____Traumatic event or experience____
__
____Osteoporosis
____Arthritis
____High/Low BP
____Open Cuts/ Sores
____Varicose Veins
____Pregnant/Breastfeeding
____Other____
____Stroke
____Diabetes
____Cancer/ Tumor
____Joint Replacement
____Neurological Problems
____Contact Lenses

To be answered by massage clients only:
When was your last massage?
____
What do you expect/hope to gain from your session today?
____
________________________ What are your focus areas and pressure preference for your massage?
____



Are there any areas of your body you would NOT like massaged? Check all that apply.
____ Face ____ Scalp ____ Ears ____ Hands ____ Feet
____ Belly ____Glutes ____ Pecs ____Other_________________________ Is massage part of your lifestyle or a luxury for you?

____

Please mark the image on the right to indicate your areas of tension or discomfort.

Consent

I affirm that I have stated all my known medical conditions and have answered all questions honestly. I understand that service is provided for the purpose of relaxation/relief of muscular tension and is NOT a substitute for medical examination, treatment, or diagnosis. For these concerns, I will seek the advice of a medical professional.
All services are non-sexual. Both the therapist and I have the right, at any time, to terminate a session.
I understand Fingers of Light requires a 24 hour notice for all reschedules and cancellations with the only exception being medical emergencies for me or a member of my immediate family. Missed appointments will be charged at 50% of the scheduled service. I accept payment for missed appointments if I fail to provide the required notice.

SIGNATURE ____ DATE ________________________

For Staff Use Only

Therapist ______________ Date_________________

Client Observations, Likes and Dislikes:

Therapist Observations:

Session Plan:

Suggested Self Care:

Plan for Next Session:

Additional Information (packages, rebooked, etc):