STATEN ISLAND MASSAGE & WELLNESS (SIMW)
Confidential Client Intake Form
(***PLEASE PRINT LEGIBLY***)

Any information that you provide on this form is strictly confidential and will only be used by Staten Island Massage & Wellness to provide you with quality service and to keep you informed of any discounts or specials we may have. We never sell, share or use any of our client's information.

Name _____ DOB _____ Who Referred You _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Email Address _____ Occupation _____

Emergency Contact Name _____ Relationship _____ Phone _____

Please help us ensure you have a safe & comfortable massage experience by providing the following information

Have you ever had a professional massage by a licensed massage therapist? Yes / No How long ago? _____

What is your desired pressure? Light / Medium / Firm / Deep

What are your goals for today's session? _____

Are you experiencing any pain today? Yes / No If yes, circle pain level Low 1 2 3 4 5 High

Are you comfortable with having the following areas massaged?
Face: Yes / No Scalp: Yes / No Pecs: Yes / No Abdomen: Yes / No
Glutes: Yes / No Hands: Yes / No Feet: Yes / No Other (explain) _____

Please check all that apply on the day of your massage & provide any necessary explanations below

____ Allergies
____ Arthritis
____ Asthma
____ Blood Clots
____ Blood Pressure (High/Low)
____ Breast Implants
____ Broken Bones
____ Cancer
____ Cardiovascular Disease
____ Carpal Tunnel
____ Circulation Issues
____ Cold/Congestion
____ Contagious Disease
____ COPD
____ Diabetes
____ Disk Injuries
____ Dizziness/Vertigo
____ Eczema/Psoriasis
____ Edema
____ Epilepsy/Seizures
____ Fainting Spells
____ Fever
____ Flu
____ Fibromyalgia
____ Headache
____ Hepatitis
____ HIV/Aids
____ Kidney Issues
____ Lupus
____ Mastectomy
____ Multiple Sclerosis
____ Numbness/Tingling
____ Osteoporosis
____ Pacemaker
____ Scoliosis
____ Sinus Issues
____ Sprains
____ Stroke
____ Thrombosis
____ Thyroid Issue
____ TMJ
____ Tuberculosis
____ Varicose Veins
____ Warts

Explanations _____

Please list any medications you are currently taking _____

Are you currently pregnant? Yes / No / Not Applicable If yes, how many months? _____

Please read the following paragraph carefully, then sign and date below

I understand that the massage that I am receiving today is being provided for the basic purpose of relaxation and relief of muscular tension and is not intended as a medical treatment or substitution for primary health care by my physician. If I experience any pain or discomfort during my massage today, I will immediately inform my therapist so that the pressure and/or strokes can be adjusted to my level of comfort. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness and that nothing said in the course of my session today should be construed as such. I affirm that I have stated any and all of my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any change in my medical profile & I understand and agree that there is/will be no liability on the therapist's part should I fail to do so for whatever reason. I hereby release SIMW (including its employees, practitioners, agents & insurers) from all liability for any injury (bodily or mental). I understand that any illicit or sexually suggestive behavior, remarks or advances made by me will result in immediate termination of the massage and I will be liable for payment in full of my scheduled appointment.

Client Signature _____ Date _____

Therapist Signature _____ Date _____