Oasis Massage
New Client Intake Form

Contact & General Information

Client Name: _____
Date of Birth: _____ Occupation: _____
Address: _____
Phone: _____ Email: _____
How would you like to receive appointment confirmations? ☐ Email ☐ Text/SMS ☐ Both
☐ Check here if you do not want to be added to our mailing list.
Emergency contact: _____ Phone: _____
Referred by: _____ Phone: _____
Were you referred by a doctor or will you be seeking reimbursement from an insurance company?
☐ Yes ☐ No If yes, a physician's prescription will be required.

Massage Information

Have you ever received professional massage/bodywork before? ☐ Yes ☐ No
If yes, how recently? _____
What types of massage/bodywork do you prefer? _____
What kind of pressure do you prefer? ☐ Light ☐ Medium ☐ Firm
What are your goals/expected outcomes for receiving massage/bodywork?
☐ Pain Management ☐ Injury Recovery ☐ Athletic Improvement ☐ Self-Care
☐ Relaxation ☐ Stress Relief ☐ Other: _____
How do you feel today? List & prioritize any symptoms (stress, pain, stiffness, numbness/tingling, swelling, etc.): _____
_____
_____
These symptoms interfere with ☐ sleep, ☐ exercise, ☐ work, ☐ childcare ☐ other: _____

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment? _____
_____
Are you wearing: ☐ contacts? ☐ dentures? ☐ a hairpiece? ☐ other prosthetic?
Are you pregnant? ☐ Yes ☐ No *If yes, please complete Pregnancy Intake.*
Are you taking any medications? ☐ Yes ☐ No *If yes, please list them below.*

Medication	*Dosage*	*Side Effects, if any*

Do you currently have any of the following:
Blood clots ☐ Yes ☐ No Infections ☐ Yes ☐ No
Congestive heart failure ☐ Yes ☐ No Contagious diseases ☐ Yes ☐ No
Pitted edema ☐ Yes ☐ No
Please answer honestly, as massage may not be indicated for the above conditions.

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Health History *(cont.)*

Please indicate conditions that you have or have had in the past. Explain & describe any treatment received.

☐ Current ☐ Past Muscle or joint pain: _____
☐ Current ☐ Past Muscle or joint stiffness: _____
☐ Current ☐ Past Numbness or tingling: _____
☐ Current ☐ Past Swelling: _____
☐ Current ☐ Past Bruise easily: _____
☐ Current ☐ Past Sensitive to touch/pressure: _____
☐ Current ☐ Past High/Low blood pressure: _____
☐ Current ☐ Past Stroke or Heart attack: _____
☐ Current ☐ Past Varicose veins: _____
☐ Current ☐ Past Shortness of breath/Asthma: _____
☐ Current ☐ Past Cancer: _____
☐ Current ☐ Past Neurological (MS/Parkinson's/chronic pain): _____
☐ Current ☐ Past Epilepsy or Seizures: _____
☐ Current ☐ Past Headaches or Migraines: _____
☐ Current ☐ Past Dizziness or Ringing in the ears: _____
☐ Current ☐ Past Digestive conditions (Crohn's/IBS): _____
☐ Current ☐ Past Gas, Bloating or Constipation: _____
☐ Current ☐ Past Kidney disease/infection: _____
☐ Current ☐ Past Arthritis (rheumatoid/osteoarthritis): _____
☐ Current ☐ Past Osteoporosis or Degenerative spine/disk: _____
☐ Current ☐ Past Scoliosis: _____
☐ Current ☐ Past Broken bones: _____
☐ Current ☐ Past Allergies: _____
☐ Current ☐ Past Diabetes: _____
☐ Current ☐ Past Endocrine or Thyroid conditions: _____
☐ Current ☐ Past Depression or Anxiety: _____
☐ Current ☐ Past Memory Loss, Confusion or Easily overwhelmed: _____

Additional Comments: _____

_____

Consent for Treatment: If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are 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 the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Cancellation & Late Policy: To avoid paying for missed appointments, a cancellation notice of 24 hours is required for all clients. Late cancellations & no-shows will be charged for 50% of the scheduled appointment. Clients who find someone to take their appointment will not be charged. Late arrivals will be accommodated, although session length may be shortened. Clients that arrive late will be charged for the full amount of the scheduled appointment, regardless of actual length of service. Clients that arrive late and opt to reschedule will be charged for the missed appointment.

Client Signature: _____Date: _____