Feeling Great
Therapeutic Massage & Lymphatic Therapy

Intake Form

370 Maple Ave. W Suite 2
Vienna, VA 22180
(703) 663-8600

Personal Information

Name: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: (_____) _____ Email:_____
Occupation: _____
Emergency Contact: _____ Phone: (_____) _____

Referred by/How did you hear about us?
_____

May we send you special offers via email?
☐ Yes ☐ No

Medical History

The following information will be used to help plan a safe and effective massage session. Please answer the questions to the best of your knowledge.

Have you ever had a professional massage before? ☐Yes ☐No

Is this a Prenatal or Postnatal massage? ☐Yes ☐No
How many months of pregnancy? _____
How many weeks after delivery? _____

Are you sensitive to touch or pressure in any area? ☐Yes ☐No

Are you currently under medical supervision? ☐Yes ☐No

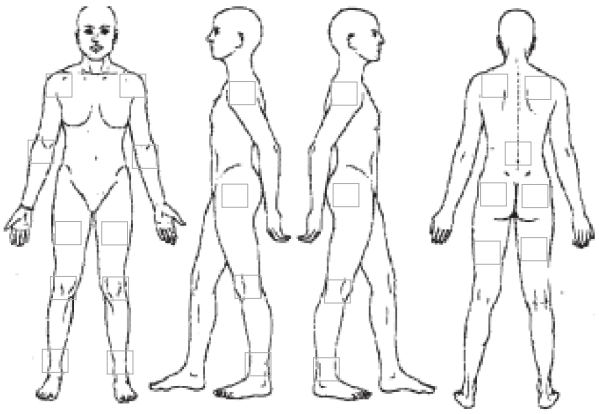
Do you see a chiropractor or physical therapist? ☐Yes ☐No

Are you currently taking medication? ☐Yes ☐No
If so, please list reason for prescription
_____
_____
_____
_____

Do you currently have, or have you ever had any of the following? (check mark if so)

☐ Recent: accident / injury / surgery / fracture
☐ Current fever
☐ Current headache/migraine
☐ Cancer
☐ Diabetes
☐ Decreased Sensation
☐ Contagious disease/skin condition
☐ Swollen glands
☐ Allergy to:_____
☐ Sensitivity / easy bruising
☐ Rheumatoid / arthritis / osteoarthritis
☐ Osteoporosis
☐ Tennis / golfer's elbow
☐ TMJ / carpal tunnel syndrome
☐ Frozen shoulder
☐ Current Sprain / strain
☐ Artificial joint / limb
☐ Fibromyalgia
☐ Epilepsy
☐ Heart condition / pacemaker
☐ Thrombosis / Atherosclerosis
☐ Varicose veins
☐ Other: _____
_____
_____
_____

Circle any specific areas you would like the massage therapist to concentrate during the session:



Comments: _____
_____
_____
_____

Please read the following statements and sign below

I _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 that I am aware of. I understand that massage therapists 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 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. Appropriate drapping will be used at all times during the session. 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 the payment of the scheduled session. I understand it is my responsibility to provide 24-hours notice before any session cancellation to avoid a cancellation fee or no-show fee. I understand there are no refunds for fees, services, packages, or gift cards/certificates.

_____ _____ _____ _____
Signature of client Date **Signature of therapist** Date

Consent to Treatment of Minor: By my signature below, I hereby authorize Feeling Great, LLC therapist to administer massage therapy or bodywork to my child or dependent as they deem necesary.
Signature of parent/guardian:_____ Date: _____