**Maria Margate, L.Ac., LMT**

Acupuncture & Massage For Wellness, Prosperity, & Longevity

margate9@yahoo.com

www.acupuncturemontclairnj.com

104 Valley Road
Montclair, NJ 07042
973-220-4242

# MASSAGE INTAKE FORM

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Name:______________________________________________ Tel. #: (______)____________________

Address:____________________________________________ Date of Birth:____________________

___________________________________________________ Age: __________________________

Referred by:_________________________________________ Tel. #: (______)____________________

In case of Emergency:__________________________________ Tel. #: (______)____________________

## General & Medical Information

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☐Male ☐Female Occupation:___________________________________
Physician:_____________________

☐Yes ☐No Have you ever experience a professional massage or bodywork session? How Recently? ____________________

**If you answer "Yes" to any of the following questions, please explain as clearly as possible.**

☐Yes ☐No Do you frequently suffer from stress?
☐Yes ☐No Do you have diabetes?
☐Yes ☐No Do you experience frequent headache?
☐Yes ☐No Are you pregnant?
☐Yes ☐No Do you suffer from arthritis?
☐Yes ☐No Are you wearing contact lenses?
☐Yes ☐No Are you wearing dentures?
☐Yes ☐No Do you have high blood pressure?
☐Yes ☐No If "Yes" to previous questions, are you taking medication for this?
☐Yes ☐No Do you suffer from epilepsy or seizure?
☐Yes ☐No Do you suffer from joint swelling?
☐Yes ☐No Do you have varicose veins?
☐Yes ☐No Do you have any contagious disease?
☐Yes ☐No Do you have osteoporosis?
☐Yes ☐No Do you have any allergies?
☐Yes ☐No Do you bruise easily?

☐Yes ☐No Have you had any broken bones in the past two years?
☐Yes ☐No Have you been in an accident or suffered any injury in the past two years?
☐Yes ☐No Do you have any tension or soreness in a specific area?
**Please-specify**:______________________
___________________________________
☐Yes ☐No Do you have cardiac or circulatory problems?
☐Yes ☐No Do you suffer from back pain?
☐Yes ☐No Do you have numbness or scabbing pain anywhere?
☐Yes ☐No Are you very sensitive to touch or pressure in any area?
☐Yes ☐No Have you ever had surgery in the past five years? **Explain.**
☐Yes ☐No Do you have any other medical condition or are you in any medication I should know about?

Comments: _______________________________
___________________________________
___________________________________

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort in 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 or 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 that I am aware of. I understand that massage/bodywork practitioner are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness. I affirm that I have shared all my known medical condition and answered all questions truthfully. I agree that the practitioner is 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.

Client Signature: ____________________________________________ Date:__________________

Practitioner Signature: ________________________________________ Date:__________________

**Consent to Treatment of Minor**: By my signature below, I hereby authorize ______________________to administer massage/bodywork or somatic therapy techniques to my child or dependant as they deem necessary.

Signature of Parent/Guardian: ________________________________________ Date:_____________