Lucas & Lucas, LLC – Massage & Bodywork Intake Questionnaire

Thank-you for choosing Lucas & Lucas, LLC for your health care needs. We know you have a choice and are glad you have decided to put your confidence in our care. Please take a moment to fill out all of the following information as accurately and thoroughly as possible.

Name: ____
Address: ____
City/State/Zip: _______________________________________
Emergency Contact Name:_______________________________
Emergency Contact Number: _____________________________
Emergency Contact Relationship:_________________________

Date of Birth:___________________________Age:__________
Primary Contact Number: Hm, Wk or Cell __________________
Secondary Contact Number: Hm, Wk or Cell ________________
E-Mail:____
Occupation:____
Referred By: ____

Have you ever had a PROFESSIONAL MASSAGE or BODYWORK session? ☐ **YES** ☐ **NO**

Reason For Visit & Goals:____

GENERAL & MEDICAL INFORMATION, PLEASE CHECK AS APPLICABLE:

Special Conditions

- ☐ In Vitro Fertilization
- ☐ Pregnancy
- ☐ Cancer
- ☐ Plantar Warts
- ☐ Diarrhea
- ☐ Infections
- ☐ Blood Clots (*WHEN?*) _______
- ☐ Seizures / Epilepsy

If any of the above are checked, PLEASE explain in the comments area of this form.

General Conditions

- ☐ Yes ☐ No Are you wearing contact lenses?
- ☐ Yes ☐ No Do you suffer frequently from stress?
- ☐ Yes ☐ No Do you experience frequent headaches?
- ☐ Yes ☐ No Do you have high blood pressure?
- ☐ Yes ☐ No Do you have circulatory problems?
- ☐ Yes ☐ No Do you have diabetes?

FOR THE FOLLOWING: *If "yes", please explain in the comments area of this form.*

- ☐ Yes ☐ No Are you sensitive to touch or pressure?
- ☐ Yes ☐ No Do you have tension or soreness in a specific area?
- ☐ Yes ☐ No Do you have pain that radiates down the arms or legs?
- ☐ Yes ☐ No Do you have numbness, tingling or stabbing pains?
- ☐ Yes ☐ No Have you ever had any broken bones or fractures?
- ☐ Yes ☐ No Have you ever had surgery?
- ☐ Yes ☐ No Do you have any other medical condition I should be aware of?
- ☐ Yes ☐ No Do you take any medications?

Comments:____
____
____
____
____
____

MASSAGE & BODYWORK IS NOT A SUBSTITUTE FOR MEDICAL CARE.
IF YOU ARE EXPERIENCING ANY SPECIFIC MEDICAL PROBLEM AND HAVE NOT SEEN YOUR MEDICAL DOCTOR, I RECOMMEND YOU DO SO TODAY.

Comments Continued: ____
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____
____

Informed Consent to Treatment

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.

By signing this form, I give my consent to a massage therapy/bodywork session. I also acknowledge I have read and understand the information below:

- I affirm that that the above health history information is correct to the best of my knowledge and I agree to keep the Massage Therapist updated as to any changes in my medical profile and understand that there shall be no liability on the practitioners part should I neglect to do so.
- I understand that massage / bodywork 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 bodywork 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 consult a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of.
- I understand that this is a professional massage therapy/bodywork session and is in no way sexual in nature. If the practitioner feels that **any** inappropriate illicit or sexually suggestive gestures, remarks or advances are made by me, this will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.
- I understand that **once I have scheduled an appointment, all other patients and clients are denied that block of time**. I may be charged the full fee for my session, if I do not provide notice of cancellation within 24 hours of the scheduled visit.

Client Signature: ____ **Date:** ____________________