FORWARD
MOVEMENT & MASSAGE

An evolved approach to pain management and performance

Intake Questionnaire

Full Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Ok to leave message? YES or NO

Email: _____ Ok to email you? YES or NO

Occupation: _____ Hours Seated per day: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Have you received a professional massage before? YES or NO

How did you hear about us? _____

Medical History

Medications currently taking (including OTC's): _____

_____

How much water do you drink daily (ounces)? _____ How many caffeinated drinks? _____

Are you currently seeing a doctor? Provide reason: _____

Are you pregnant or trying to conceive? YES or NO Gestation: _____

Are therapeutic grade essential oils ok to use? YES or NO

Heat preference: NONE / LOW / MODERATE / HIGH

Are there areas that you do **not** want worked on? _____

Do you exercise regularly? List activities & frequency:

_____

_____

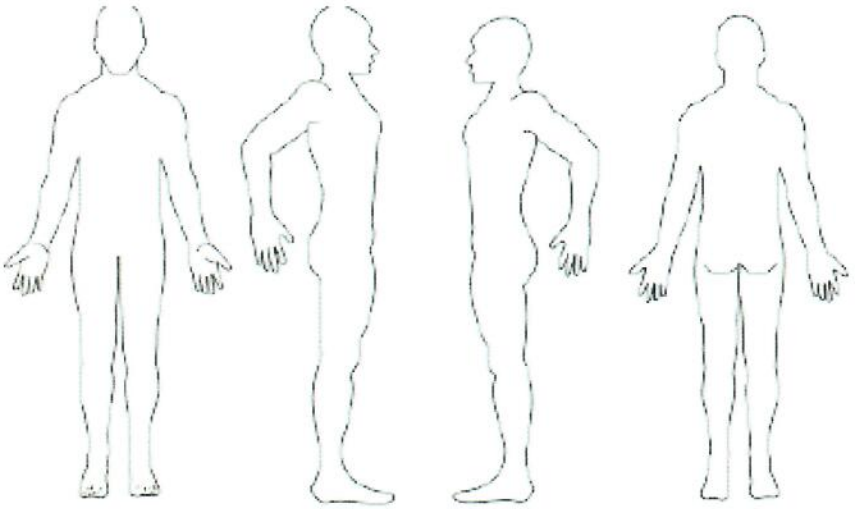
Would you like more information on personal training services that focus on functional movement, strength training, and mobility/stretching and other self-care techniques? YES or NO

Please indicate health conditions and provide explanation.

Health Condition	Yes	No	If yes, please explain.
Allergies			
Arthitis			
Auto-immune disorder			
Blood clots			
Cancer			
Cardiovascular disease			
Carpel tunnel syndrome			
Deep vein thrombosis			
Diabetes			
Headaches			
High or low blood pressure			
Internal or external pacemaker			
Joint surgery			
Kidney disease			
Liver disease			
Major accident or injury			
Neck or back injury			
Numbness and/or tingling			
Other:			
Recent injury			
Pain			
Skin condition			
Surgeries			
Temporomandibular Joint Dysfunction			
Tendinitis			
Vericose veins			

Use page 2 to list additional information.

Please mark any areas of pain or discomfort you are experiencing currently.



Please describe any sharp, shooting/referring, or throbbing. Include sensations of numbness, tingling, or dull, tight, and aches.

_____

_____

_____

_____

_____

(Health Conditions continued from page 2:)

_____

_____

_____

_____

_____

Massage Bodywork Consent and Privacy Policy

Massage Therapy: I understand that massage therapy and bodywork is intended to enhance relaxation, reduce stress, increase range of motion, and offer relief from muscular tension, spasm or pain. I also understand that it may increase circulation and energy and blood flow. If I experience any pain or discomfort during this session, I will immediately inform the massage therapist so that the pressure may be adjusted to my comfort level. I have been notified that, for therapeutic benefit, discomfort may be present and will be discussed and agreed upon by, both myself, and the massage therapist. The general benefits of massage therapy, possible contraindications, and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition that I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

Accessory Techniques: I understand that I may also receive deep pressure, sports massage, acupressure and/or TuiNa massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. They could include, but are not limited to: bruising, sore muscles or aches, pain or discomfort, and the possible aggravation of the symptoms existing prior to treatment. I understand that GuaSha and cupping therapy are for the purpose of relief from muscular tension or spasm and for increasing circulation and energy flow. I understand that GuaSha & cupping therapy may cause side effects like bruising and some discomfort. Forward Movement & Massage has informed me of these things and I understand their meaning and may refuse treatment. The therapist will discuss if cupping is indicated for treatment.

Privacy Policy: The information received and collected from my visit is strictly private and confidential. It is used and viewed only by the healthcare professionals associated with Forward Movement & Massage, unless, in my best interest, a practitioner determines that there is a need to communicate with another person or healthcare professional outside of Forward Movement & Massage, Forward Movement & Massage, will not give, share or transfer any personal information to a third- party unless required by law. Under absolutely no circumstances will this communication happen without my signed consent. *Please notify us if you would like to receive a copy of our privacy policy.*

Pricing & Fees: Standard rates are $100/hr and $130/90 mins. Cancellations within 24 hours may be subject to paying full session fee. Returned checks are subject to a $25 fee.
_____**INITIALS**

Privacy Statement

I, _____, have been offered a copy of Forward Movement & Massage's Consent & Privacy Policy. I have read all policies and I understand them. The procedures of the massage, general information about massage and massage benefits, as well as specifics of the therapy, have been explained to me. I also understand that the therapist and I have the right to refuse or terminate the massage session at any time.

Sign Name _____**Date**_____

If under age of 18, guardian signature is required.

Biomat Contraindications and Cautions

Please indicate any of the following conditions by circling and provide details. Therapist will discuss this list with you and determine if infrared is safe for you and an appropriate temperature.

CONTRAINDICATED / DO NOT USE	***NEGATIVE IONS ONLY***	***TEMP. Rx 95 - 113 F***
External pacemaker	Heat-sensitive Multiple Sclerosis	Bypass surgery
Hemophilia or hemorrhage	Fever	Brain tumor
Infections	Radiation or chemotherapy	Diabetes
Newborn (under 6 mos)		High or low blood pressure
Organ transplant		Internal pacemaker
Renal or kidney failure		Young children
		Pregnancy
GENERAL CAUTIONS		
Surgical implants	Be aware. Consult physician with pain.	
Silicone implants	Regarded safe. Consult surgeon with pain. (394F)	
Pain while on mat	Be aware. Discontinue if persists.	
Condition worsens while on the mat	Be aware. Discontinue if persists.	
Pharmaceuticals	*Research individually.*	
Corticosteroids	Be aware, may cause redness. Discontinue if persists.	
Joint injury	Do not use if less than 48 hrs.	

Disclosure Statement

I, _____, have reviewed the above lists of health conditions, including "Biomat Contraindications and Cautions", and have informed the massage therapist of all my known physical conditions, medical conditions and medications. I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the therapist's part should I fail to do so. I have carefully read all the above information and am fully aware of what I am signing. I understand that I may ask the massage therapist for additional information before signing this consent form. I give my permission and consent to massage therapy.

Signature _____ **Date**_____

If under age of 18, guardian signature is required.