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Initials	Circle one	Service or promotion
For Official Use Only		

Beacon Massage

Client Massage Intake Form

Welcome to Beacon Massage, your beacon to wellness. The road to a relaxed, healthier you starts here. In order to treat you to the fullest, safest massage, we require just a brief amount of information, including some private health information. **This form must be filled out completely before we can begin.** We take special care in the privacy of the information provided. Your information is confidential and is protected through a complex encryption process and is shared with no one. If you have any questions and concerns with regard to confidentiality, please address it immediately with your Beacon Massage Therapist.

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General Client information

Please Print Clearly

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Male: _____ Female: _____

Email Address: _____ Date of Birth: _____

Occupation: _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Client Medical Information

Information provided is to ensure a safe treatment and is kept confidential.

Are you under the care of a physician? Yes: No:

If yes, what is the condition: Condition: _____

Are you currently taking medications? Yes: No:

If yes, name and amount: Name & Amount _____

Have you had any surgeries? Yes: No:

If yes, please describe & list dates: Surgery & Dates _____

Have you had any injuries or accidents? Yes: No:

If yes, please describe? Accidents or injuries _____

Are you pregnant? (Female Clients only) Yes: No:

If yes, how many weeks? Pregnancy complications? _____

In order to provide you with the safest possible massage, please check if you have any of the following conditions and explain below:

<input type="checkbox"/> Infection/Infectious Disease	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Liver, Kidney, or Urinary
<input type="checkbox"/> Edema/Inflammation	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Numbness or Tingling	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Skin Conditions
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Other Cardiovascular Disease	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Cancer or Tumors	<input type="checkbox"/> Stroke	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other: _____

Explanation for any of the above: _____

Please complete reverse side

Beacon Massage

Client Massage Health Intake Form



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How did you hear about Beacon Massage?

Have you ever had massage?

Yes:

No:

If Yes, How Often?

Are you here for a Relaxation or Clinical Therapeutic Massage?

Relaxation: _____ Clinical: _____

While a Relaxation Service is not inclusive of other modalities, such as Prenatal or Deep Tissue, your therapist will do their best to provide the desired massage as long as it's in the scope of the paid service. Please ask your therapist if you would like to upgrade your Relaxation to a Clinical Therapeutic Massage to meet enhanced expectations. (Additional fee applicable)

Client Preferences

The Following information you provide below will only be used by your therapist to gain a basic understanding of your preferences for massage. A detailed treatment will be discussed during the initial interview.

What would you like to have accomplished today? _____ Long term? _____

Check any applicable areas of the body you would like your therapists to focus on today:

All (No specific focus): Upper Body Only: Lower Body Only:

*Head/Scalp: <input type="checkbox"/>	*Face: <input type="checkbox"/>	Neck: <input type="checkbox"/>	Chest (Collar Bone Area only): <input type="checkbox"/>
Shoulders: <input type="checkbox"/>	Upper Back: <input type="checkbox"/>	Middle Back: <input type="checkbox"/>	Lower Back: <input type="checkbox"/>
*Glutes: <input type="checkbox"/>	Arms/Hands: <input type="checkbox"/>	Legs: <input type="checkbox"/>	Feet: <input type="checkbox"/>

Check any applicable areas of the body you would **not** like massaged:

*Head/Scalp: <input type="checkbox"/>	*Face: <input type="checkbox"/>	Neck: <input type="checkbox"/>	Chest (Collar Bone Area only): <input type="checkbox"/>
Shoulders: <input type="checkbox"/>	Upper Back: <input type="checkbox"/>	Middle Back: <input type="checkbox"/>	Lower Back: <input type="checkbox"/>
*Glutes: <input type="checkbox"/>	Arms/Hands: <input type="checkbox"/>	Legs: <input type="checkbox"/>	Feet: <input type="checkbox"/>

* Denotes area that may not be part of a regular treatment. Please indicate if it is an area you want worked.

What amount of pressure of touch do you prefer? (Circle Area)

Lighter Pressure Medium Pressure Firmer Pressure

Client/therapist disclaimer

Please read carefully

Beacon Massage wants to be a part of your healthcare team. We want to provide a safe, pleasant environment for all of our clients. As such, our policies and procedures are in place to ensure the successful treatment for our clients and massage therapists. The massage/bodywork provided by our therapists is to enhance the wellness of the client and therapists are required by Massachusetts State law to adhere to the principles and guidelines of the codes of conduct for massage therapy. However, massage therapy licensure does not allow therapists to diagnose medical conditions; therapists can assess and recommend only. Therapists are forbidden to work outside their scope of practice. If you have questions or concerns regarding the individual scope of practice for each therapist, please ask. We encourage the asking of questions, no matter how slight or insignificant they appear to be in order to clarify any understanding.

Beacon Massage Therapists will, at all times be respectful to our clients and expect the same courtesy. All medical information provided the client is necessary for the therapist to provide a safe and thorough treatment. Any medical information not disclosed by the client may put the client at risk. Therefore, due to the lack of information, clients cannot hold the therapist liable for any delayed or recurring physical problems as a result.

Client Agreement

Sign and date below

As the client, I agree I will not hold Beacon Massage & Beacon Massage therapists in any and all liability arising from the application of massage therapy, unless the therapist is in violation of the AMTA Code of Ethics and/or Standards of Practice. (Provided Upon Request)

Beacon Massage reserves the right to refuse service at any time, if client rating falls below a manageable level, and/or is in violation of Beacon Massage policies and procedures, including, and not restricted to, any actions that could reasonably be construed as sexual in nature or any behavior that exhibits harassment, as defined by the therapist performing the massage.

I, as a client of Beacon Massage, agree to pay for services rendered. If a dispute with regard to payment, I know I am liable for payment and will need to pay upon completion of services first, and seek recourse for a refund if I am not fully satisfied.

I have read the above statement and agree to the terms listed above. It is my choice to receive massage, and I give my full consent to receive massage from Beacon Massage, of Beacon Massage, 45 Newbury St., Suite 208 Boston, MA 02116.

Client Signature

Date