CONFIDENTIAL CLIENT INTAKE FORM

dream**clinic** ™

PERSONAL INFORMATION

Name ______________________________ Date ____________________

Address ______________________________ City ______________ State ______ Zip ________

Primary Phone ______________ Secondary Phone ______________ Date of Birth ______________

Email Address ______________________ How did you hear about us? ______________________

Employer ______________________ Occupation ______________________

Emergency Contact ______________________ Emergency Contact Phone ______________________

MASSAGE HISTORY / TREATMENT INFORMATION

Have you ever received a professional table massage? ☐**Yes** ☐**No** Date of last massage ______________

List any exercise and stress reduction activities and frequency: ______________________

____

Are there specific areas of your body you want the massage to focus on today? ______________

____

What results do you want from your massage sessions? ______________________

____

PREVIOUS HISTORY

Allergies: ____

Surgeries: ____

____

Injuries/Accidents: ____

____

Major Illnesses or other hospitalizations: ______________________________________

____

Are you currently seeing a medical practitioner? ☐ Yes ☐ No If yes, please give name and location:

____

If necessary, do we have permission to consult with your medical practitioner? ☐ **Yes** ☐ **No**

Are you currently seeing a psychotherapist or attending support group meetings? ☐ **Yes** ☐ **No**

Please explain if yes: ____

____

List current medications, including aspirin, ibuprofen, etc. ______________________________

____

Cancellation Policy:

Dreamclinic requires at least **24 hours' notice** if you need to cancel or reschedule your appointment for any reason. For no-shows or cancellations with less than 24 hours' notice, Dreamclinic, Inc. will charge a cancellation fee.

As a courtesy to your massage therapist, if you arrive late for your appointment, your session will be billed the full rate while we may have to shorten the duration of the session.

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Please identify any of the following, which you now have or have had in the past:

Now	Past		Now	Past		Now	Past	
		Skin Conditions			**Nervous System Conditions**			**Digestive Conditions**
❑	❑	Rash	❑	❑	Numbness	❑	❑	Constipation
❑	❑	Allergy	❑	❑	Tingling	❑	❑	Diarrhea
❑	❑	Fungal Infection	❑	❑	Nerve Damage	❑	❑	Ulcer
❑	❑	Other	❑	❑	Shingles	❑	❑	Other
			❑	❑	Other			
		Muscle Conditions						
❑	❑	Strain			**Respiratory Conditions**			**Other Conditions**
❑	❑	Tendonitis	❑	❑	Sinus			
❑	❑	Spasm	❑	❑	Lung / Bronchial	❑	❑	____________________
❑	❑	Cramp	❑	❑	Other			
❑	❑	Other				❑	❑	____________________
					Circulatory Conditions			
		Joint Conditions	❑	❑	Heart	❑	❑	____________________
❑	❑	Sprains	❑	❑	Blood Pressure			
❑	❑	Arthritis	❑	❑	Arteries	❑	❑	____________________
❑	❑	Degenerating Joints	❑	❑	Veins			
❑	❑	Other	❑	❑	Other			

I have listed all my known medical conditions such as surgeries, injuries, diseases, physical limitations and medications and will inform the massage therapist of any change in my physical health between massage sessions. I understand that a massage practitioner must be aware of any existing physical conditions that I have in order to provide appropriate massage.

I also understand that a massage practitioner neither diagnoses nor prescribes for illness, disease, or any other medical, physical or emotional disorder, nor performs any thrusting joint or spinal manipulations or adjustments. I am responsible for consulting a qualified primary care provider for any physical ailment that I may have.

I understand that massage does not involve any form of touch of genitalia or nipples and I understand that these areas will be draped at all times during the massage. Should the massage practitioner not be clear and acting differently from these expectations, I agree to speak to him or her any time I feel my wellbeing is being compromised.

TRANQUILITY SERVICES

Dreamclinic Tranquility Services are designed to help create a more relaxed state in the body and mind, much like meditation. It is considered safe in most instances, however, on rare occasions, mild side effects have been reported, such as slight drowsiness, vertigo or feeling of nausea during or after the first session. Adjusting the volume or positioning the chair in a more upright position may minimize these effects. Furthermore, the service may not be advisable in the presence of severe acute inflammation (excluding normal flu), major internal or external bleeding, and in cases of severe heart disease. Please consult with your physician before undergoing a vibroacoustic session if you are at risk of heart attack, have a pacemaker or are pregnant.

I understand the above potential risks and participate in vibroacoustic sessions at my own risk.

My signature below indicates that I have read and understand all the statements above.

Client Signature ____ **Date**__________________________