Oxford Massage Studio
6115 La Vista Dr. #200, Suite 107
Dallas, TX 75214

Massage Client Intake

Name ____ Date of Birth _________________________
Address ____ City ____________________________
State ___________ Zip ___________________ Phone ____
Email ____
How did you hear about us? ______________________________ Referred By ____________________________
Emergency Contact Name and Phone __________________________________ ________________________

Massage Information

Have you had a professional massage before? □ Yes □ No

If yes, how frequently do you get a massage?

____

If yes, do you have a style or pressure preference?

Specify: □ light □ medium □ firm pressure

□ Other _____________________________________

What type of massage are you seeking today?

□ Relaxation □ Deep Tissue □ Therapeutic □ Sports

□ Pregnancy □ Hot Stones □ Other ________________

What do you hope to accomplish with today's massage?

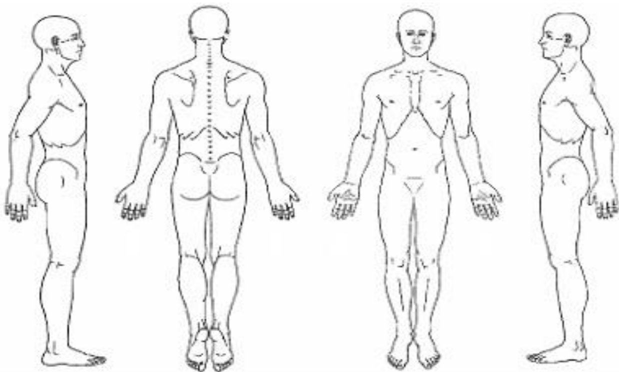
____
____

Do you have any known allergic reactions? □ Yes □ No

If yes, please describe___________________________

What are your common areas of pain or tension?

____



Medical History

Do you suffer from chronic pain/discomfort?

□ Yes □ No If so, for how long? ______________

____

Do you know what causes/caused it or when the symptoms seem to get worse or better?

____

Are you currently under medical care? □ Yes □ No

Are you currently taking any prescription medication?

□ Yes □ No If so, please name meds and reason

____

____

Please indicate any condition that you have had or currently have:

- □ Headaches/Migraines
- □ Allergies/Sensitivity
- □ Arthritis/ Tendonitis
- □ Bruise Easily
- □ Cancer/Tumors
- □ TMJ Problems
- □ Abnormal Skin Condition
- □ Heart/Circulatory Issues
- □ High/Low Blood Pressure
- □ Varicose Veins
- □ Currently Pregnant
- □ Blood Clots
- □ Epilepsy/Seizures
- □ Neck/ Back Injuries
- □ Diabetes
- □ Fibromyalgia
- □ Numbness
- □ Sprains/ Strains
- □ Joint Replacement

Explain any condition marked above: ____
____
____
____

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Consent for Treatment

By signing this consent, I agree that I have stated all health conditions that I am aware of and the information is accurate to the best of my knowledge. I will inform my massage therapist if anything changes in my status. I understand that the bodywork I receive is for the purpose of stress reduction and relief from muscular tension. If I experience any pain or discomfort, I will immediately inform my massage therapist that the pressure and/or methods can be adjusted to my comfort level.

I understand that a massage therapist cannot diagnosis illness, disease, or any physical or mental disorders. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal or skeletal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and/or diagnosis and I understand that it is my responsibility to consult a physician for any ailments I may have.

Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. I understand that I am receiving massage therapy at my own risk. I understand that draping will be used during my massage session and that only the area being worked on will be uncovered. Sexual advances and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated, resulting in immediate termination of the session and I will be liable for payment of the scheduled treatment.

I agree to abide by a 24 hour cancellation notice for any scheduled massage. I understand I may be charged up to the full amount of service for missed appointments or for any cancellations with less than a 24 hour notice.

I agree that I am of legal age (18 years old) and that if I am not, I agree to have my parent or guardian sign a parental/guardian release form before treatment.

Signature of Client ____ **Date** _____________

Signature of Massage Therapist ____________________________________ **Date** ______________