Melody’s Massage Studio

4366 Old William Penn Hwy. unit B
Monroeville, PA 15146
412-374-9400 or 412-609-8773

I understand that massage therapy involves neither diagnosis nor treatment of any condition as it is not a substitute for medical care.

I understand that massage is beneficial to my physical, mental and emotional health and that massage is not intended for sexual gratification. I do not expect any forms of sexual services from the therapist. Draping will be used at all times; neither my breasts (female) nor genital areas will be massaged.

I understand that if anytime I am uncomfortable with the massage or any technique being used, I can ask the therapist to stop, change techniques, or end the session.

I understand that I am responsible for providing medical information to my therapist.

I understand that 24 hours notice is required to cancel an appointment or the session will be paid in full before I can reschedule my next appointment.

***How Did You Hear About Us? –**

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Name: **(print clearly)** ____

Signature: ____

Date: ____

Client Intake Form

(Please Print Clearly)

Date: ____________

Name: ______________________ Sex: ☐ Male ☐ Female

Address: ______________________________________

City: ______________ State: ______ Zip: __________

Home Telephone: __________ Cell Phone: __________

Work Telephone: __________ e-mail: ______________

Birth Date: ______________ Marital Status:

Occupation: ______________________ ☐ Single ☐ Married

Primary Health Care Provider: ______________________________

In Case of Emergency, Please Notify:

Name: ______________ Telephone: __________

Relationship: ______________________

______________________________ ____________

Signature Date

Children under the Age of 16 Must Have Parental Consent

______________________________ ____________

Signature Date

Health History

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

- ❑ Headaches
- ❑ Joint stiffness/swelling
- ❑ Spasms/cramps
- ❑ Broken/fractured bones
- ❑ Strains/sprains
- ❑ Back, hip pain
- ❑ Shoulder, neck, arm, hand pain
- ❑ Leg, foot pain
- ❑ Chest, ribs, abdominal pain
- ❑ Problems walking
- ❑ Jaw pain/TMJ
- ❑ Tendinitis
- ❑ Bursitis
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Scoliosis
- ❑ Bone or joint disease
- ❑ Other: ____________________

Circulatory and Respiratory

- ❑ Dizziness
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Cold feet or hands
- ❑ Cold sweats
- ❑ Swollen ankles
- ❑ Pressure sores
- ❑ Varicose veins
- ❑ Blood clots
- ❑ Stroke
- ❑ Heart condition
- ❑ Allergies
- ❑ Sinus problems
- ❑ Asthma
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Lymphedema
- ❑ Other: ____________________

Skin

- ❑ Rashes
- ❑ Allergies
- ❑ Athlete's Foot
- ❑ Warts
- ❑ Moles
- ❑ Acne
- ❑ Cosmetic surgery
- ❑ Other: ____________________

Digestive

- ❑ Nervous stomach
- ❑ Indigestion
- ❑ Constipation
- ❑ Intestinal gas/bloating
- ❑ Diarrhea
- ❑ Diverticulitis
- ❑ Irritable bowel syndrome
- ❑ Crohn's Disease
- ❑ Colitis
- ❑ Adaptive aids
- ❑ Other: ____________________

Nervous System

- ❑ Numbness/tingling
- ❑ Twitching of face
- ❑ Fatigue
- ❑ Chronic pain
- ❑ Sleep disorders
- ❑ Ulcers
- ❑ Paralysis
- ❑ Herpes/shingles
- ❑ Cerebral Palsy
- ❑ Epilepsy
- ❑ Chronic Fatigue Syndrome
- ❑ Multiple Sclerosis
- ❑ Muscular Dystrophy
- ❑ Parkinson's disease
- ❑ Spinal cord injury
- ❑ Other: ____________________

Reproductive System

- ❑ Pregnancy:
  - ❑ Current ❑ Previous
- ❑ PMS
- ❑ Menopause
- ❑ Pelvic Inflammatory Disease
- ❑ Endometriosis
- ❑ Hysterectomy
- ❑ Fertility concerns
- ❑ Prostate problems

Other

- ❑ Loss of appetite
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Difficulty concentrating
- ❑ Drug use ____________________
- ❑ Alcohol use ____________________
- ❑ Nicotine use ____________________
- ❑ Caffeine use ____________________
- ❑ Hearing impaired
- ❑ Visually impaired
- ❑ Burning upon urination
- ❑ Bladder infection
- ❑ Eating disorder
- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Post/Polio Syndrome
- ❑ Cancer
- ❑ Infectious disease (please list) ____________________
- ❑ Other congenital or acquired disabilities (please list) ____________________
- ❑ Surgeries ____________________
- ❑ Other: ____________________

For clients who need mobility assistance, please give your height: ________ weight: ________

Please list any additional comments regarding your health and well-being: ____________________

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I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's Signature: ______________________________ Date: ____________________

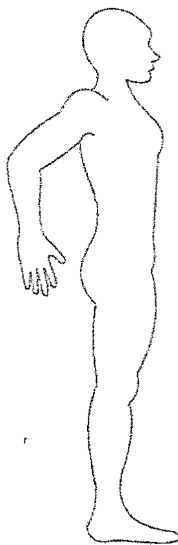
Client Status Report

Name: ______________________________ Date: ____________

Please identify current problem areas in your body by drawing the appropriate symbols on the diagrams below.

Key

- ◯ Circle areas where pain exists
- Circle areas with small dots where extreme pain exists
- X Put an "X" over stiff areas
- Draw squiggly lines over areas of numbness or tingling
- Mark scars, bruises or wounds



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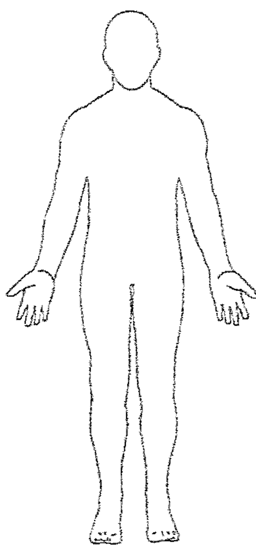
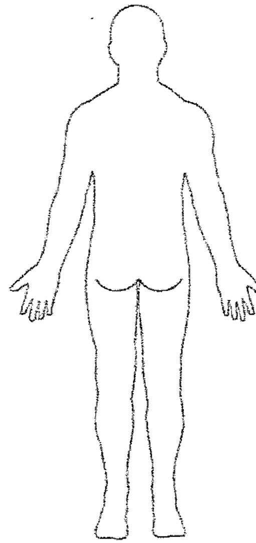


Front



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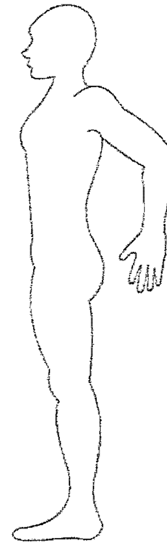

Left

Comments: ______________________________

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