Katie Kloss LMT
900 NW 8th Avenue
Gainesville, FL 32601
352.328.9971

Massage Therapy Intake Form

Name ____ Date _________________________

Address ____
Street City State Zip

Date of Birth _________________ Occupation _________________ Phone # ___________________

Emergency Contact ____
Name Relationship Phone Number

What are your goals and/or expectations for this therapy session?

____

____

Have you ever received massage or other bodywork before? Yes No

If yes, please describe your experience:

____

____

Are you currently taking any medications or supplements? Yes No

If yes, please explain:

____

____

Have you ever had surgery and/or been hospitalized for any reason? Yes No

If yes, please explain:

Have you suffered any major injuries in the past five years? Yes No

If yes, please explain:

Are you currently seeing a physician, physical therapist, or chiropractor for any ongoing issue? Yes No

If yes, please explain:

Do you have any allergies and/or skin sensitivities? Yes No

If yes, please explain:

Do you have any restrictions or limitations that would affect your ability to receive massage? Yes No

If yes, please explain:

Are there any specific areas of your body that you would like me to focus on? Yes No

If yes, please specify:

Are there any specific areas of your body that you would like me to avoid? Yes No

If yes, please specify:

Are you currently experiencing any pain? Yes No

If yes, please rate your current pain level on the following scale:

0 1 2 3 4 5 6 7 8 9 10

Are you currently experiencing any stress? Yes No

If yes, please rate your current stress level on the following scale:

0 1 2 3 4 5 6 7 8 9 10

Are you wearing contact lenses? Yes No

Are you wearing a hearing aid? Yes No

Are you wearing dentures? Yes No

Do you have a pacemaker? Yes No

Are you taking any blood thinners? Yes No

Do you bruise easily? Yes No

Are you currently pregnant? Yes No __________ weeks

Please indicate all of the following conditions that apply to you (past or present).

Y	N		Y	N	
○	○	anemia	○	○	insomnia
○	○	anxiety	○	○	low blood pressure
○	○	asthma	○	○	lupus
○	○	autoimmune condition	○	○	migraines
○	○	back pain	○	○	multiple sclerosis
○	○	blood clots	○	○	muscle strain/sprain
○	○	broken bones	○	○	neuropathy
○	○	bruxism	○	○	numbness/tingling
○	○	bursitis	○	○	osteoarthritis
○	○	cancer	○	○	osteoporosis
○	○	cardiovascular disease	○	○	panic disorder
○	○	carpal tunnel syndrome	○	○	paralysis
○	○	chemical dependency (drugs/alcohol)	○	○	Parkinson's disease
○	○	chronic fatigue	○	○	plantar fasciitis
○	○	chronic pain	○	○	psoriasis
○	○	constipation	○	○	PTSD
○	○	Crohn's disease	○	○	respiratory issues
○	○	depression	○	○	rheumatoid arthritis
○	○	diabetes	○	○	sciatica
○	○	dizziness	○	○	scoliosis
○	○	edema	○	○	seizures
○	○	epilepsy	○	○	shingles
○	○	fibromyalgia	○	○	sinus problems
○	○	headaches	○	○	stroke
○	○	heart attack	○	○	tendonitis
○	○	hemophilia	○	○	thrombosis
○	○	hepatitis	○	○	TMJ disorder/dysfunction
○	○	herpes simplex	○	○	tuberculosis
○	○	high blood pressure	○	○	varicose veins
○	○	HIV/AIDS	○	○	whiplash
○	○	IBS	○	○	other ___________________

Please use the space below to explain all YES answers:

____

____

____

____

____

____

I, ______________________________________, voluntarily consent to receive therapeutic massage services, including any related modalities within the scope of practice of my licensed massage therapist. I affirm that all of the information I have provided in this agreement is true and accurate to the best of my knowledge. I assume full responsibility for notifying the therapist of any changes to my physical and/or mental health that may occur at any point during the course of treatment. I hereby waive and release my therapist and any affiliated massage establishments and/or entities from all liability (past, present, and/or future) relating to massage therapy and/or bodywork.

I understand that my personal health information and any other client records maintained by my therapist are private and confidential. I understand that my information will not be disclosed or released to any third party without my prior written consent or a subpoena or other court order.

I understand that massage therapists are not physicians and that massage therapy should not be construed as a substitute for medical examination and/or treatment provided by a licensed physician. I understand that massage therapists do not diagnose any physical or mental illnesses, that they do not prescribe any medical treatments or drugs/medications, and that they do not perform any spinal or skeletal manipulations. I understand that any and all information provided to me by my therapist is strictly intended for general educational purposes only and is not diagnostically prescriptive in nature.

I understand that payment is due in full at the time of service unless otherwise specified by the therapist. I agree to pay for each session with either cash or a credit/debit card (Visa, AmEx, Mastercard, Discover). I understand that my massage therapist does not accept checks as a form of payment. I agree to adhere to the following rates for each session unless otherwise specified by the therapist:

$35 / 30 minutes
$65 / 60 minutes
$95 / 90 minutes

I understand that if I am late for an appointment, the length of that session will not be extended. I agree that I will still be liable for the full payment of that appointment. If I need to cancel or reschedule an appointment for any reason, I agree that I must contact my massage therapist at least 24 hours before my scheduled appointment time in order to avoid being charged a fee. I understand that I will be responsible of the full value of the missed appointment. Emergency circumstances will be considered on an individual basis.

I understand that massage therapy is strictly professional in nature. I agree that any form of misconduct on my behalf, including but not limited to any sexually suggestive or otherwise inappropriate remarks and/or gestures, will absolutely not be tolerated. I understand that any such misconduct will result in the immediate termination of the session. I understand that I will be held accountable for the full payment for the terminated appointment and that I will not be allowed to book any future appointments at this establishment.

I affirm that I have carefully read this agreement in its entirety and that I fully understand and agree to all of the terms and conditions enumerated therein. I acknowledge that I am signing this legally binding document on my own free will.

______________________________ ______________________________
Client Signature Date

______________________________ ______________________________
Therapist Signature Date