

# Lotus on the Nile Wellness Center

Acupuncture ☐ Herbal Medicine ☐ Massage ☐ Yoga *and so much more!*

4307 S. Crenshaw Blvd.

Los Angeles, CA 90008

323.295.6887 or 323.29.LOTUS

www.lotusonthenile.com

## MASSAGE INTAKE FORM

Client Name \_\_\_\_\_ Date \_\_\_\_\_

Please fill out all information as accurately and as thoroughly as possible.

It is better to provide what you consider too much information, rather than too little. Leave blank any areas indicated

**MASSAGE THERAPIST USE ONLY.** Place a question mark next to any items you are unclear about.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #1: ( ) \_\_\_\_\_ - \_\_\_\_\_ Phone #2 ( ) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Emergency Contact and their relationship to you:

\_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

Relationship to you \_\_\_\_\_

Were you referred by anyone? ☐Yes ☐No If so, whom? \_\_\_\_\_

What type of pressure do you prefer? \_\_\_\_\_

Have you ever received massage or bodywork before? ☐Yes ☐No If yes, how was it? \_\_\_\_\_

What therapeutic benefit would you like to receive from this massage?

\_\_\_\_\_

Would you like me to focus on or stay away from any specific area(s)?

\_\_\_\_\_

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### HEALTH INFORMATION

Have you been diagnosed with or do you have any of the following? Y=Yes N=No

Smoker? ☐Yes ☐No

Contagious Disease? ☐Yes ☐No

High/Low Blood Pressure? ☐Yes ☐No

Open sores or wounds? ☐Yes ☐No

Allergies? ☐Yes ☐No

Epilepsy? ☐Yes ☐No

Seizures? ☐Yes ☐No

Diabetes? ☐Yes ☐No

Frequent Headaches? ☐Yes ☐No

Varicose Veins? ☐Yes ☐No

Cancer? ☐Yes ☐No

Nausea? ☐Yes ☐No

Dementia? ☐Yes ☐No

Heart Conditions? ☐Yes ☐No

Active Phase of Eczema or Skin Rashes? ☐Yes ☐No

Sensitivity to Bodycare Products such as Essential Oil Infused Oils or Creams, Liniments, etc.? ☐Yes ☐No

High Level Stress? ☐Yes ☐No

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### WOMEN ONLY

Are You Currently Pregnant? ☐Yes ☐No

**Do you experience any of the following before your period? Check all that apply**

- ☐ Tension ☐ Irritability ☐ Anger ☐ Short-temper ☐ Breast Tenderness ☐ Skin Outbreaks ☐ Pelvic Pain/Cramps ☐ Drop in Energy ☐ Headaches ☐ Heat Sensation ☐ Depression ☐ Crying ☐ Sadness ☐ Insomnia ☐ Low Back Pain ☐ Pebble-like stools ☐ Constipation

**Do you experience any of the following?**

Menstrual Cramps? ☐Yes ☐No

Uterine Fibroids? ☐Yes ☐No

Endometriosis? ☐Yes ☐No

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Heavy Bleeding? Yes No

Painful Periods Yes No

### MASSAGE THERAPIST USE ONLY

Do you have any medical conditions for which you would like to see our holistic health practitioner? Yes No

Are you currently suffering from any pain related to traumatic experience (i.e.: Car accidents, sports injuries, surgeries)

Yes No

If yes, briefly explain (what and when): \_\_\_\_\_

Are you currently taking any medications or supplements (prescribed or non-prescribed)? Yes No

If yes, please list with dosage and frequency:

**I attest that the above is true and accurate to the best of my knowledge. I further acknowledge that:**

**Massage Therapy is a professional form of treatment used to relieve structural and emotional tension and stress. On occasion the client may experience a healing crisis as toxins and emotional stressors are released from the body. It is therefore important that all information provided above is complete and accurate and that I consume a full glass of water following treatment. Massage treatment may include effleurage, gentle stretches, light tapping, and pressure holds. I understand that a massage therapist is not a doctor and cannot prescribe medications or diagnose medical conditions.**

**Therapists do not discriminate on the basis of race, religion, sexual preference or gender.**

**Therapists reserves the right to end session in the case of sexual innuendo or advances from client, and client has same right in instance of sexual advances or innuendo from therapist.**

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Client Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

Date: \_\_\_\_\_

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WELLNESS CENTER