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

Patient Name:_______________________________________ Date:_____________ Date of Birth:______ _______

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)?

 MT Initials:_____________

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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 Vericose 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

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
Heavy Bleeding? □Yes □No Painful Periods □Yes □No

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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):____

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 to drink a full glass of water following treatment. Massage treatment may include effleurage, gentle stretches, light tapping, and pressure holds. 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 will immediately end session in the case of sexual innuendo or advances from client.

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Signature Date:

 MT Initials:____________