AMERICAN ACADEMY OF INTERNATIONAL EDUCATION, INC.

Faculty of Health & Medicine – School of Therapeutic Massage

Therapeutic Massage Lab Client For Student Massage – Health Information Intake Form & Contract

Student-Therapist:_____**Date:**_____
Supervisor/Instructor:_____

A. Client Information:

Full Name:_____Gender: □ Male □ Female □_____
Home Address:_____Tel:_____(Home)
_____ Tel:_____(cell)
Email Address:_____ _____
Date of Birth:_____Weight:_____ Social Security #_____
Occupation:_____Employer:_____Tel:_____
Emergency Contact:_____ Relationship:_____
Cell Tel:_____Email:_____

B. Current Health Information: Please include Rx, pain-relievers, over-the-counter drugs (OTC) herbal remedies, Homeopathic or Natural Medicine, Vitamins/Minerals, etc.

Current Medications:	**Past Medications:**
1._____	1._____
2._____	2._____
3._____	3._____
4._____	4._____
5._____	5._____
Blood Pressure: Systolic/Diastolic:_____	**Blood Pressure: Systolic/Diastolic:**_____
Smoking: □ Yes □ No - **Vaping**: □ Yes □ No	**Smoking**: □ Yes □ No - **Vaping**: □ Yes □ No

C. Health History: Please list & explain: Include approximate dates & treatment received. Note if still under Primary Care's care for anything listed.

Surgeries:_____
_____
_____

Injuries:_____
_____
_____

COVID-19: Have you had COVID? □ Yes □ No - Are you vaccinated: □ Yes □ No _____

Major Illnesses and/or disabilities:_____

Psychological or Mental Health:_____

D. Current Conditions: Please check **ALL** that apply. Please feel free to comment – as necessary:

□ Anxiety_____
□ Auto-Immune Disorder_____
□ Arthritis_____
□ Backache_____
□ Bruise Easy_____
□ Cancer _____
□ Cardiovascular_____
□ Carpel Tunnel Syndrome_____
□ Chronic Fatigue Syndrome_____
□ Cystic Fibrosis_____
□ Depression_____
□ Dermatitis (Skin Problems)_____
□ Diabetes_____
□ Fibromyalgia_____
□ Headache & Migraine_____

☐ Neck, Shoulder or Arm Pain_____
☐ Numbness or Tingling_____
☐ Osteoporosis_____
☐ Pain_____
☐ PTSD_____
☐ Seizures_____
☐ Sinus Problem_____
☐ Sleep Disturbances_____
☐ Spasms, Cramps_____
☐ Spinal Problem_____
☐ Stiff or Painful Joints_____
☐ Varicose Veins_____
☐ Weak or Sore Muscles_____
☐ Weight Gain/Loss _____
☐ Other:_____

E. Allergies:

☐ Scents, Oils, Lotions:_____
☐ Detergents, Fabric Softeners:_____
☐ Other:_____

F. Activities of Daily Living: Please check any which are currently aggravated or limited:

☐ Work	☐ Running	☐ Playing with Family
☐ Computer Work	☐ Bending	☐ Recreational Sports
☐ Driving	☐ Lifting	☐ Other:
☐ Sitting	☐ House Work	☐ Other:
☐ Standing	☐ Self-Care	☐ _____
☐ Walking	☐ Sleep	☐ _____

Contract for Care: In signing, I the client, understand & agree that Massage Therapy is for General wellness purposes only and for stress reduction, and that the Massage Therapist;

- Has the right to refuse treatment if client appears to be under the influence of drugs/alcohol, high blood pressure or for other undisclosed reasons.
- Will never touch genitals, females breast tissue or other areas clients instructs therapist not to touch
- Is not trained to, and does NOT diagnose physical/mental illness or disease or prescribe medical treatments, spinal manipulations or pharmaceuticals.

It is the client's responsibility to seek appropriate healthcare provider for diagnosis & treatment of any suspected medical problem and to inform the massage therapists of any existing or potential health conditions. In signing this contract, the client/parents/caregiver expressly gives her/his consent to the appropriate massage, as determined by the student & agreed by the instructor. The client, parent(s) and/or registered caregiver (**please circle**) expressly releases the student, the instructor, the school and its administrators & staff, etc. of any liability whatsoever.

Signature of Client:_____ Date:_____

Signature of Parents/Guardian/Caregiver:_____Date:_____

☐ I allow ☐ Do not allow you to communicate with my healthcare provider & health insurer to keep them informed of this massage therapy treatment. We highly recommend that your physician/insurer be made aware of all treatments you are getting, including any OTC, Vitamins, etc. ☐ If you wish, we would be happy to send a report to ☐ your physician ☐ health insurance company ☐_____.

Name of your Physician:_____City/State:_____Tel:_____

Health Insurance Company: _____Policy #_____Expiry Date:____

Time started:_____Time finished:_____ Oil/Lubricants Used:_____ _____
Comments:_____
Amount Paid: Teacher/Supervisor's evaluation/Grade/Signature:

- Health Insurance companies generally do not pay for massage, but we can try to negotiate for such coverage.