

# CLIENT INTAKE & CONSENT FORM

(PLEASE COMPLETE ALL SECTIONS OF THE FORM)

## Consent:

I give the therapist permission to work on the following areas of my body:

- \_\_\_\_\_ Head
- \_\_\_\_\_ Face
- \_\_\_\_\_ Neck
- \_\_\_\_\_ Shoulders
- \_\_\_\_\_ Back
- \_\_\_\_\_ Chest
- \_\_\_\_\_ Arms
- \_\_\_\_\_ Hands
- \_\_\_\_\_ Abdominals
- \_\_\_\_\_ Buttocks
- \_\_\_\_\_ Pelvis  
(Not genitals)
- \_\_\_\_\_ Legs
- \_\_\_\_\_ Feet

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

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

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

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

OK to Contact-check all that apply: Cell #\_\_ Home #\_\_ Address\_\_ Email\_\_

Known Health Conditions: \_\_\_\_\_  
\_\_\_\_\_

Medications taken in the last month: \_\_\_\_\_  
\_\_\_\_\_

Reason for today's Massage: \_\_\_\_\_  
\_\_\_\_\_

How/where did you first hear about the office: \_\_\_\_\_

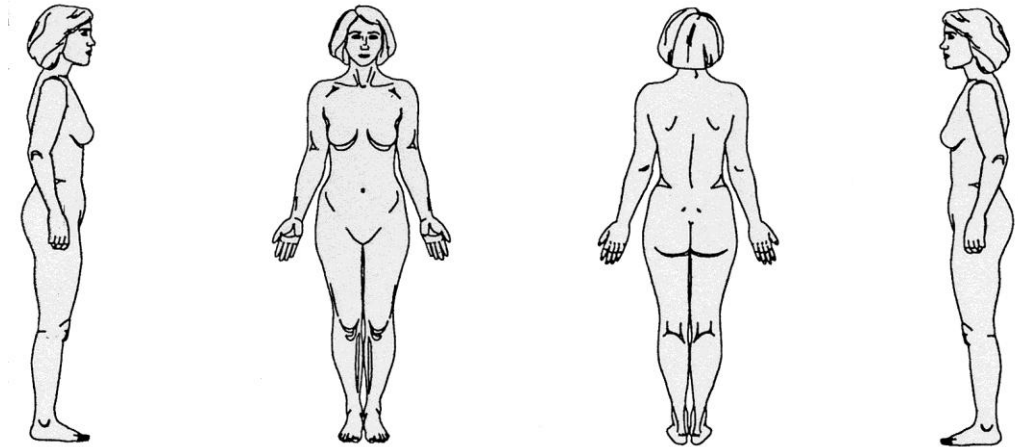
Please mark areas of tension, stress or pain you are experiencing on the figures below:

## Statement of Understanding

Massage is a valid health practice and form of stress relief and relaxation.

I understand that massage is beneficial to my physical, mental and emotional health.

I understand that massage is not intended for sexual gratification. I do not expect any form of sexual service from the therapist.



Any additional information about you the therapist should know: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge the information I have provided is accurate and true. The massage therapist has reviewed the information herein and has explained the draping procedures and the general techniques he intends to use. I understand that if at any time I am uncomfortable with the massage or any technique being used, I can ask the therapist to stop, change techniques, or to end the massage session.

Client Initials

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

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## General:

- High Blood Pressure
- Low Blood Pressure
- Area of Inflammation  
Where \_\_\_\_\_
- Chest Pains
- Heart Attack / MI
- Shortness of Breath
- Diabetes
- Osteoporosis
- Varicose Veins / Phlebitis
- Seizures / Convulsions
- Dizziness / Fainting
- Sinus / Allergies
- Bruise Easily
- Skin Condition  
Where \_\_\_\_\_
- Infectious Condition  
Where \_\_\_\_\_

## Head:

- Headaches
- Migraines
- Light Headedness
- Loss of Memory
- Ringing in the Ears
- Accident / Stitches  
Where \_\_\_\_\_
- Other \_\_\_\_\_

## Neck:

- Pain w/ movement
- Herniated Disk
- Limited Movement
- Throat Infections

## Jaw:

- TMJ
- Grind Teeth
- Pain

## Shoulders:

- Limited Movement
- Injuries / Surgeries
- Bursitis

## Arms:

- Shooting Pains
- Loss of Strength

## Abdomen:

- Nausea
- Constipation
- Gas
- Diarrhea
- Appendicitis
- Liver Trouble
- Gall Bladder Trouble
- Bladder Trouble
- Kidney Trouble
- Stomach Acidity
- Digestive Problems
- Ulcers
- Other \_\_\_\_\_

## Back:

- Herniated Disk
- Pinched Nerves
- Low Back Pain
- Limited Movement
- Surgeries
- Other \_\_\_\_\_

## Pelvis / Legs / Feet:

- Ovary Problems
- Painful Menstrual Cramps
- Leg Cramps
- Swollen Ankles
- Hip Pain

## Nervous System / Other:

- Insomnia
- Nervousness / Anxiety
- Twitching of Face / Eye
- Inner Tension
- Nightmares
- Depression
- Irritability
- Chronic Fatigue
- Fibromyalgia
- Manic Depressive
- Other \_\_\_\_\_
  
- HIV / AIDS (confidential-  
will not affect session)

Do you have any other medical condition, physical illness or limitation that I need to be aware of before you receive massage therapy? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe:

\_\_\_\_\_

\_\_\_\_\_

Because a Massage Therapist must be aware of any existing physical condition the I have, I have listed all my known medical conditions and physical limitations and I will inform the Massage Therapist in writing of any change in my health.

I understand that the massage therapy I am given is for the purpose of stress reduction, relief from muscle tension or spasm, and / or for improving circulation. I understand that a Massage Therapist neither diagnoses illness, disease, or any other medical, physical or mental disorder; nor performs any spinal manipulations. I am responsible for consulting a physician for any physical ailment that I have.

I agree to pay for services at the time they are rendered unless prior arrangements are made.

Signature \_\_\_\_\_ Date \_\_\_\_\_