

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: _____

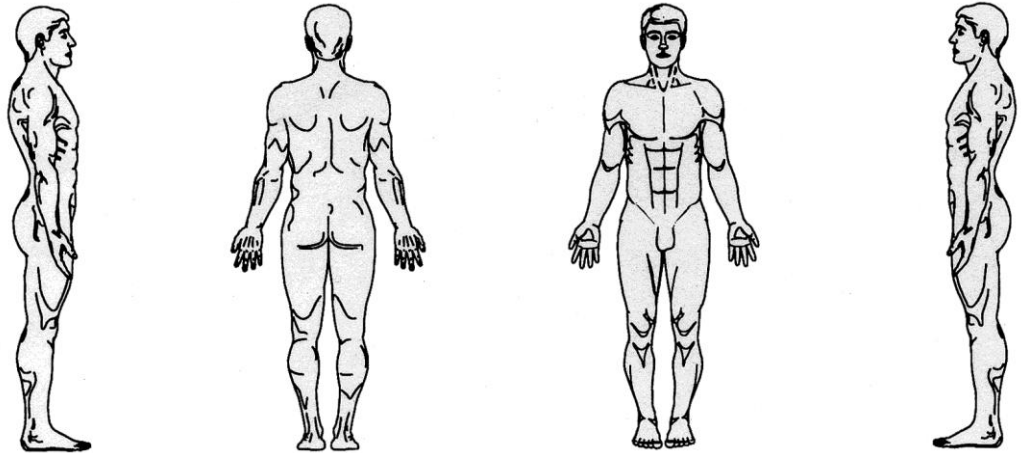
Reason for today's Massage: _____

I prefer to be draped in the following manner:

- _____ Full Sheet
- _____ Towel

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:

- Prostate Problems
- 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 _____