Intake Form Part 1

Clients Name _____

DOB: _____ Phone number _____

Email: _____

Address: _____

Emergency Contact _____

Occupation _____

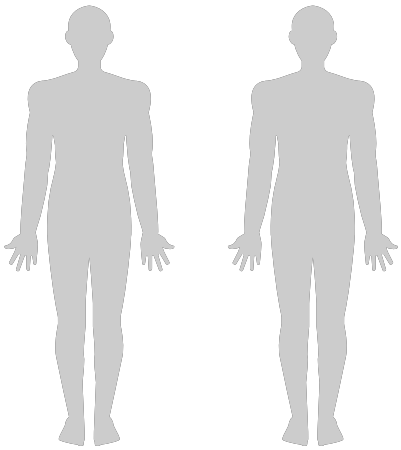
Are you taking any medications?

☐ Yes ☐ No If Yes, what kind? _____

Do you suffer from chronic pain?

☐ Yes ☐ No

If Yes, what kind? Please specify the areas and give more details.



Have you ever received Massage Therapy?

☐ Yes ☐ No

Have you consumed alcohol in last 72h?

☐ Yes ☐ No

Intake Form Part 2

Do you have any allergies or sensitivities?

☐ Yes ☐ No If Yes, what kind? _____

Do you have any of the following?

☐ Sun Burn
☐ Cold
☐ Burns
☐ Pain
☐ Bruises
☐ Rush
☐ Cuts
☐ Heart Conditions
☐ High/Low Pressure
☐ Broken Caterpillars

Please specify any medical conditions that were not mentioned:

Clients Name _____

Signature _____ Date _____

Medical History

Clients Name _____

Age: _____ Phone number _____

Email: _____

Address: _____

Emergency Contact _____

Occupation _____

Do you experience any of Joint Pain / Soft Tissue

- [ ] Neck
- [ ] Upper Back
- [ ] Shoulders
- [ ] Midback Area
- [ ] Low Back
- [ ] Arms
- [ ] Hips
- [ ] Legs / Knees
- [ ] Feet
- [ ] Joints

Do you experience any of the conditions?

- [ ] Headache / Migraine
- [ ] Ear Problems
- [ ] Vision Problems
- [ ] Vision Loss
- [ ] Hearing Loss

Do you experience any of the conditions?

- [ ] Skin Conditions
- [ ] HIV
- [ ] Herpes
- [ ] Skin Conditions
- [ ] Hepatitis

Cardiovascular conditions:

- [ ] Heart Attack
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Heart Disease

Other possible conditions:

- [ ] Allergies
- [ ] Epilepsy
- [ ] Asthma
- [ ] Cancer

Client consent form

I hear by consent to and authorize the following massage therapist, Tamara Scott to perform the following massage therapy procedure:
.....

I have voluntary elected to undergo this massage therapy procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards involved by the following massage therapist, Tamara Scott.

I acknowledge that the massage therapist is not a physician and does not diagnose medical conditions. I understand that massage therapy is not a substitute for a medical examination or treatment.
It is recommended that I see my personal physician for any issues that I might be experiencing.

I have read and understood the post-treatment home care instructions and understand how important it is to follow all the instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home post-treatment care, I will consult my massage therapist immediately.
I have also, to the best of my knowledge, given an accurate account of my medical history, including allergies or prescription drugs or products that I am currently ingesting or using topically.

I have read and understood this agreement and all information detailed above. I understand the procedure and accept the risks. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement.
I do not hold the massage therapist, whose signature appears below, responsible for any conditions that were present, but not disclosed at the time of this massage therapy procedure, which may be affected by the treatment performed today.

Clients Name _____

Signature _____ Date _____

Therapist name _____

Signature _____ Date _____

Cancellation Policy

We are committed to providing all of our clients with exceptional care in a timely manner.
For this reason, we have instituted a 24-hour cancellation policy for all appointments. The massage therapist needs to be notified 24 hours prior to the appointment date in order to avoid a cancellation or no-show fee of $50 for any Massage Therapy visits. We appreciate your understanding and cooperation.

PATIENT CONSENT

I have read this policy and understand that I need to provide at least 24 hours notice when rescheduling or cancelling an appointment. If I fail to contact the office at least 24 hours in advance I will be charged the appropriate cancellation fee of $50.

CLIENTS NAME _____

SIGNATURE _____ DATE _____

FOR OFFICE USE ONLY

Credit Card Information:

☐ Visa ☐ Mastercard ☐ American Express ☐ Discovery

CARD NUMBER _____

EXP DATE _____