LEAVEN MASSAGE THERAPY- Client Intake Form

Personal Information:

Name _____ Phone (Day) _____ Phone (Eve) _____

Address _____

City/State/Zip _____

email _____ Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge.

Date of Initial Visit _____

1. Have you had a professional massage before? Yes No

   If yes, how often do you receive massage therapy? _____

2. Do you have any difficulty lying on your front, back, or side? Yes No

   If yes, please explain _____

3. Do you have any allergies to oils, lotions, or ointments? Yes No

   If yes, please explain _____

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses ☐ dentures ☐ a hearing aid ☐?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No

   If yes, please describe _____

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No

   If yes, please describe _____

8. Do you experience stress in your work, family, or other aspect of your life? Yes No

   If yes, how do you think it has affected your health?

   muscle tension ☐ anxiety ☐ insomnia ☐ irritability ☐ other _____

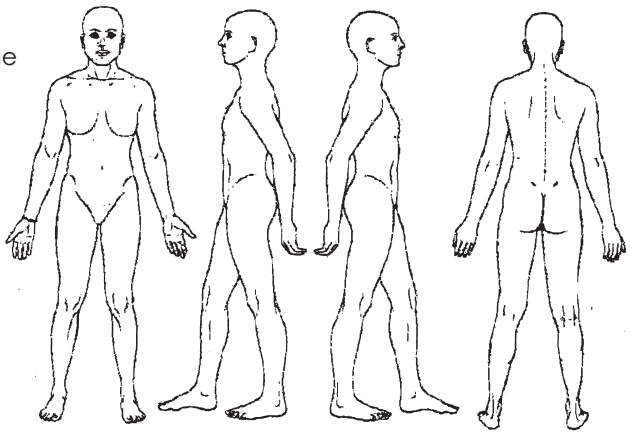
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

   If yes, please identify _____

10. Do you have any particular goals in mind for this massage session? Yes No

    If yes, please explain _____

Circle any specific areas you would like the massage therapist to concentrate on during the session:



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Medical History:

In order to plan a massage session that is safe and effective,
I need some general information about your medical history.

11. Are you currently under medical supervision? Yes No
    If yes, please explain _____
12. Do you see a chiropractor? Yes No If yes, how often _____
13. Are you currently taking any medication? Yes No
    If yes, please list _____
14. Please check any condition listed below that applies to you:

- ☐ contagious skin condition
- ☐ open sores or wounds
- ☐ easy bruising
- ☐ recent accident or injury
- ☐ recent fracture
- ☐ recent surgery
- ☐ artificial joint
- ☐ sprains/strains
- ☐ current fever
- ☐ swollen glands
- ☐ allergies/sensitivity
- ☐ heart condition
- ☐ high or low blood pressure
- ☐ circulatory disorder
- ☐ varicose veins
- ☐ atherosclerosis
- ☐ phlebitis
- ☐ deep vein thrombosis/blood clots
- ☐ joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
- ☐ osteoporosis
- ☐ epilepsy
- ☐ headaches/migraines
- ☐ cancer
- ☐ diabetes
- ☐ decreased sensation
- ☐ back/neck problems
- ☐ Fibromyalgia
- ☐ TMJ
- ☐ carpal tunnel syndrome
- ☐ tennis elbow
- ☐ pregnancy If yes, how many months?

Please explain any condition that you have marked above _____

_____

_____

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

_____

Informed Consent:

This record of consent is required before the first assessment or treatment and will be maintained confidentially in the client file. It may only be released to a third party with prior written consent of the client.

Massage Therapy includes the assessment and treatment of the soft tissues and joints of the body, using soft tissue manipulation, joint mobilization. Treatment plans will be discussed in advanced with the client and must be agreed upon prior to start of the session

I _____ hereby request and consent to the performance of massage therapy by the therapist signed below.

I am indicating to my massage therapist those areas that I do not want included in my massage some common areas: ☐ scalp ☐ abdomen ☐ chest ☐ breast (must receive written consent for breast massage)
☐ face ☐ buttocks ☐ feet ☐ other_____

Massage in general provides benefits of stress reduction, relief from muscular tension, spasm, or pain, and it increases circulation and energy flow. I understand that massage therapists do not diagnose illness or disease, perform any spinal manipulations, nor do they prescribe any medical treatments and that nothing said in the course of the session given should be construed as such. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of.

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Informed Consent Continued

I understand that massage may provide benefits for certain conditions but results are not guaranteed nor will it "cure" my health problems. I also understand that massage therapy may produce side effects such as muscle soreness, mild bruising, increased awareness of areas of pain and light-headedness amongst other possible temporary outcomes.

The therapist must be made aware of all health conditions due to certain contraindications (advised against because of possible adverse reactions) or cautions for massage. I have disclosed all such conditions. I will also update any changes to my health in future sessions.I understand & agree that there shall be no liability on the therapist's part should I fail to do so.

Privacy will be assured as I have the right to undress only to my comfort level and according to the requirements of the treatment.
Draping will be used by the therapist as required to expose only those parts of my body that require treatment and/or as I choose to ensure my comfort during treatment. During treatment, the therapist will endeavor to work such that a pain level of 6 - 7 is not exceeded, based on a pain scale of 1 - 10.

The therapist understands that I have the right to question procedeures used and to receive an explanation of any procedures that the therapist performs during the therapy session

If at any time during the massage the client or therapist is uncomfortable for any reason, they shall immediately say so. I understand that at any time I may withdraw my consent and treatment will be stopped.Sexual advances of any kind will not be tolerated.Inappropriate actions or language is cause for the termination of treatment and the client will be responsible for payment of the appointment in full. We reserve the right to refuse service to anyone.

Children are not permitted in the massage room unless they are recieving massage therapy. Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17. Otherwise childcare must be provided for them during the massage. Leaven Massage Therapy does not provide childcare services.

Promptness is expected for all appointments. In the event of lateness, the massage may be cut short due to courtesy and commitments to subsequent clients. Fees will be maintained per the schedule.

Cancellation of any appointment must be received at least 24 hours in advance; otherwise 50% of the appointment fee is due. After 2 consecutive cancellations, you will be billed for the 3rd cancellation if your slot is not filled. No call, no shows will not be rescheduled after their 2nd no call, no show.

Fees for treatment are due prior to departure on the day of the treatment. Cash or credit cards accepted.

Signature of client _____ Date _____

Signature of Massage Therapist_____ Date_____