Confidential Client Intake Form and Release of Liability

Name:_____ E-mail:_____

Address:_____ Home phone:_____

City, State, Zip:_____ Cell phone:_____

DOB:_____ Work phone:_____

Occupation:_____ Referred by:_____

Emergency contact:_____ Phone:_____

Physicians name:_____ Phone:_____

General Health Information

Have you had professional bodywork before? If yes, how often do you receive bodywork?_____

Do you have any allergies or sensitivities to oils, lotions, scents, etc?_____

What are your exercise habits?_____

How much water do you drink daily?_____

Are you under the supervision of a physician for any health concerns?_____

_____

Any current medications?_____

_____

Any surgical history?_____

_____

Please mark an (X) for current conditions and a (P) for past conditions

__ Abdominal/Digestive problems	__ Chronic pain	__ Hernia	__ Rheumatoid Arthritis
__ AIDS/HIV+	__ Circulatory/Heart problems	__ High/Low Blood Pressure	__ Sciatica
__ Headaches	__ Currently pregnant	__ Insomnia	__ Severe Tension/Stress
__ Anxiety	__ Depression	__ Migraines	__ Spinal disorders
__ Arthritis	__ Diabetes	__ Muscle Spasms/Cramps	__ Sprains/Strains
__ Asthma or lung conditions	__ Disc Problems	__ Muscle injuries	__ Varicose veins
__ Blood clots	__ Fatigue	__ Numbness/tingling	__ Rash/fungus
__ Carpal Tunnel	__ Fibromyalgia	__ Osteoarthritis	__ Tendonitis/Bursitis
__ Cancer	__ Lupus	__ Osteoporosis	__ TMJ (jaw pain)

Other:_____

Reason for today's visit

What would you like to focus on with today's treatment?

_____

_____

_____

How long have you been having this issue?_____

Have you sought medical attention for this issue?_____

Have you tried and/or gotten relief with any other treatments?_____

_____

_____

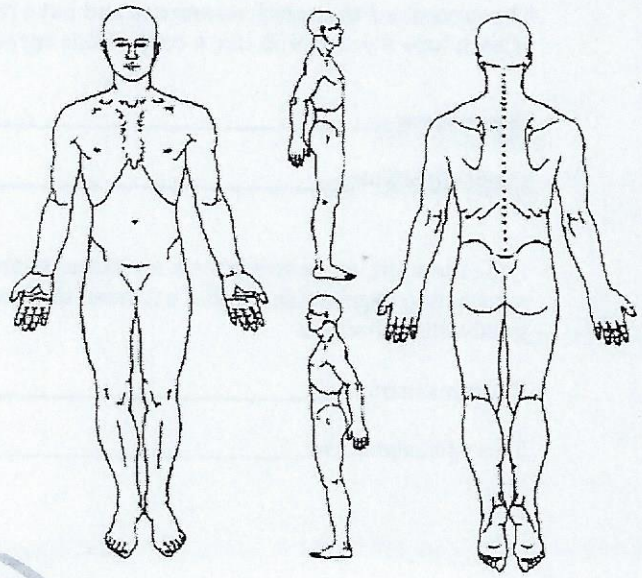
Please rate on a scale from 0 – 10 (10 being very high)

___ Stress ___ Pain ___ Energy

Please circle any areas of pain or tension on the diagram to the right

Please mark with an "X" any areas you would like avoided

(genital and breast areas will always be avoided)



OVER →

Bodywork Client Waiver Form

Please take a moment to read and initial each of the following statements:

If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.

___

I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

___

I affirm that I have notified my therapist of all known medical conditions and injuries. I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.

___

I understand that bodywork is entirely therapeutic and non-sexual in nature.

___

By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

___

I understand that should I cancel an appointment less than 24 hours before the scheduled time or "no show" an appointment, I am subject to a fee equal to the cost of the missed appointment. If the appointment was booked under a gift certificate, it will be voided in lieu of the fee.

___

Information and Suggestions

- Prior to your massage, please remove contact lenses and all jewelry. Pull long hair back with a clip or band.
- In general, massage is given while you are unclothed. However, you may choose to wear clothing (loose, comfortable clothing will not interfere with your treatment). You will be covered with a top sheet throughout your session. This is your massage and you should be as comfortable as possible.
- Feel free to ask your therapist any questions before, during, or after the session. Your therapist is a highly trained healthcare professional and wants to make you feel informed and comfortable.

I have received the policy statement, and have read and agree to the policies therein.
(Check here if you would like a copy of this agreement ___)

Client name:_____

Client signature:_____ Date:_____

I, the therapist, agree to perform my duties to the best of my ability keeping client health, safety, well-being and satisfaction foremost in mind. I will keep all client information and details in strict confidence as indicated by law and good ethical practice.

Therapist name:_____

Therapist signature:_____ Date:_____