

**Client Intake Form**

Name \_\_\_\_\_ Referred by \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_

Please confirm appointments at Home# \_\_\_\_\_ Work/Cell # \_\_\_\_\_

Email: \_\_\_\_\_ Birth month/day \_\_\_\_\_

Emergency Contact Name/Number \_\_\_\_\_

Mark here if you would like to be on my mailing list (coupons, specials, newsletter ) \_\_\_\_\_  
Information is never shared or sold and you can opt out at any time.

Have you had a professional massage before? No/Yes    Do you wear contact lenses? No/Yes  
Are you currently experiencing or do you have a personal history of: (circle all that apply)  
Skin Problems Diabetes                      Fainting                      Arthritis (osteo, rheumatoid)  
Headaches                      Pulled Muscles                      Inflammations Allergies (food, mold)  
Back, Neck Injuries    Heart/Blood Pressure Problems  
Recent Surgery \_\_\_\_\_

Location(s) of Fractures/Dislocations \_\_\_\_\_

Location(s) of Numbness/Tingling \_\_\_\_\_

**Females:** Are you pregnant? No/Yes                      Due Date \_\_\_\_\_  
Do you have a history of menstrual cramping?                      No/Yes/Not applicable

Other information \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Requests for physical or verbal sexual gratification will not be tolerated and will result in cessation of session, forfeiture of session fees and police notification.**

\_\_\_\_\_ (Initial)

Payment is expected at each session. Processing fee of \$15.00 is added to late payments. Cancellations not made at least 24 hours in advance may be charged the session fee. Three “no shows” will result in a termination of our professional relationship. To receive the multiple session discount payment must be made at or prior to the first session. \_\_\_\_\_ (Initial)

Communication and respect of boundaries (yours and mine) are important in the session. Please keep me informed of your comfort level so that techniques, temperature, music and lighting can be adjusted accordingly. \_\_\_\_\_ (Initial)

Texas Dept. of State Health Services requires me to inform you of the techniques I will be using and the areas to be massaged. **I incorporate many techniques in each session based on the information you provide me.** Some techniques I may use include swedish strokes, reflexology, deep tissue, stretching, cranial-sacral and Ortho-Bionomy® as well as other techniques we discuss. **Your massage will generally address muscles** on the back, neck, arms, legs, hands & feet as well as abdomen, gluteal and head unless you specify differently. **You have the right to stop the session at any time. Should your reason for receiving a massage change, please notify me** so it can be noted on the session form. **Draping will be used at all times** unless mutually agreed upon. **Any child under the age of 17** must have a parent or legal guardian written consent. **Breast massage** must have written consent prior to work. (I do not do breast massage). Ortho-Bionomy® is a registered trademark of the International Society of Ortho-Bionomy & is used with permission

**Privacy Policy:** Any information pertaining to the medical condition, including session treatments, personal &/or medical background will not be disclosed to any party without signed consent of the client. Clients may request to view their own information at any time. However, no information will be released without prior written consent of the client unless required by law. Information maintained on electronic database (book keeping software program) involves payment history, name, address, phone number and birth date. Personal information is not shared or sold to any third party at any time.

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

I give consent for my minor child \_\_\_\_\_ to receive massage

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

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

Request to view information / Permission granted to \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_  
signed