Massage Therapy

CLIENT INTAKE FORM

Name _____ Date _____

Address _____ Emergency contact _____ Phone _____

Phone _____ Email Address: _____

Date of Birth:_____ Referred by:_____

Health Information

Are you under a Physician's care if so explain:_____

Have you received massage therapy or bodywork before? ☐ Yes ☐ No

Are you on any medication? ☐ Yes ☐ No If yes, which ones _____

Do you exercise? ☐ Yes ☐ No If yes, how many times per week ? ____ How many hours? ____

**Please mark any of the following conditions you may currently have.

☐ Abdominal/digestive	☐ Athlete's foot	☐ Depression
☐ Asthma/lung	☐ Constipation/diarrhea	☐ Hearing
☐ Circulatory/heart	☐ Headaches	☐ Low blood pressure
☐ Fatigue	☐ Jaw pain/TMJ pain	☐ Pregnancy
☐ High blood pressure	☐ Numbness/tingling	☐ Spinal disorders
☐ Muscle/joint pain	☐ Sleeping	☐ Varicose veins
☐ Sinus	☐ Vision	☐ Arthritis/tendonitis
☐ Tension/stress	☐ Anxiety	☐ Chronic pain
☐ Allergies	☐ Blood clots	☐ Sprain/strain
☐ Diabetes	☐ Muscle/bone injuries	☐ Other
☐ Hernia	☐ Rash/fungus	_____

Elaborate on noted areas above:_____

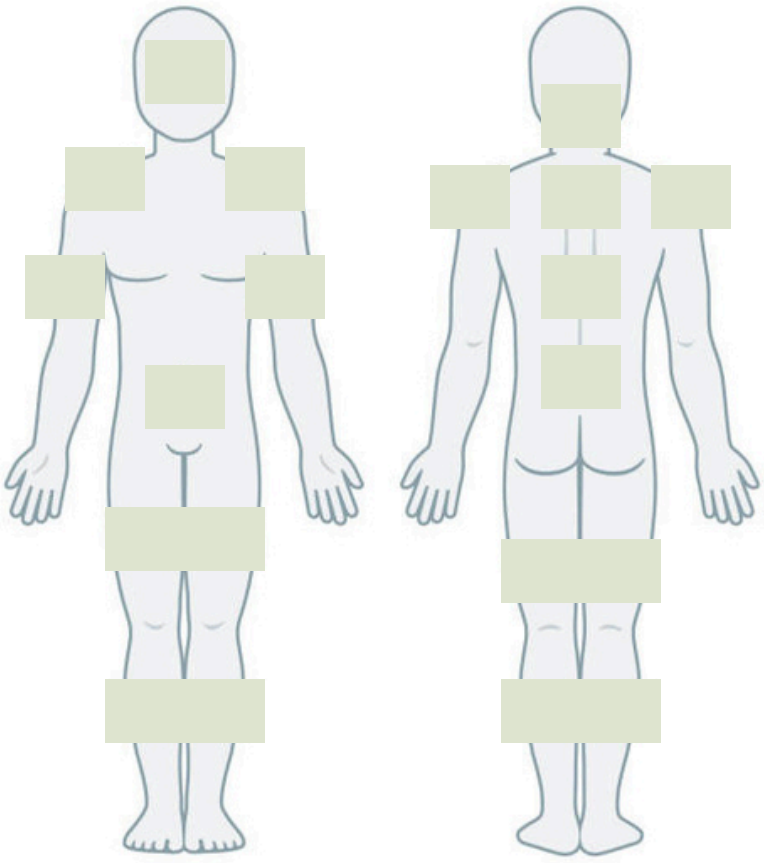
Please list any recent injuries or surgeries:_____

Do you participate in sports, exercise, hobbies, or stress reduction activities_____

If yes what are they_____

Massage Therapy Client Intake

Please mark the areas to identify your symptoms today. Select the area in roughly the area of your pain/tenderness, numbness/tingling, or joint/muscle stiffness



I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I will inform my health care provider and massage therapist if anything changes in my status. I understand that massage therapy I receive is for the purpose of stress reduction and relief of muscular tension, spasm, or pain and to increaze circulation. If I experience any pain or discomfort, I will immediately inform my massage therapist so that the pressure and/or methods can be adjusted to my comfort level. I understand that my massage therapist does not diagnose illness or disease, nor perform any spinal manipulations, and does not prescribe any medications or treatments. I acknowledge that massage is not a substitute for a medical examination or diagnosis and that I should see my health care provider for those services. If I am unable to attend my scheduled appointment, I will respect and abide by the set cancellation policies. Sexual advances, requests for sexual favors, and any other verbal or physical conduct of a sexual nature will be considered sexual harassment and will not be tolerated. I understand that I am receiving massage therapy at my own risk. In the event that I become injured either directly or indirectly as a result, in part or in whole, of the aforesaid massage therapy, I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.

Signature:_____ **Date:**_____

General Liability Release Form

By signing below, you agree to the following:

1) I give my permission to receive massage therapy
2) I understand that therapeutic massage is not a substitute for traditional medical treatment or medications.
3) I understand that the massage therapist does not diagnose illnesses or injuries, or prescribe medications.
4) I have clearance from my physician to receive massage therapy.
5) I understand the risks associated with massage therapy included, but not limited to:

* Superficial bruising
* Short-term muscle soreness
* Exacerbation of undiscovered injury

I therefore release the company and the individual massage therapist from all liability concerning these injuries that may occur during the massage session.
6) I understand the importance of informing my massage therapist of all medical conditions and medications I am taking, and to let the massage therapist know about any changes to these. I understand that there may be additional risks based on my physical condition.
7) I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so he/she may adjust accordingly.
8) I understand that I or the massage therapist may terminate the session at any time.
9) I have been given a chance to ask questions about the massage therapy session and my questions have been answered.

_____ _____

Signature Date

Minor Consent Form

Minors are permitted to receive massage services at Studio Zen LLC

A parent or legal guardian must be present in completing the Health History Form for the minor and to sign the policies.

Guidelines:

- Minors (under age 18) can only receive massage with written consent from parent or guardian.
- The consenting adult, child and therapist will establish goals for the massage sessions(s).
- For clients age 15 and under, the parent or guardian must be present in the treatment room or give written consent.
- For clients age 16-17 if both client and parent or guardian are comfortable with child in the treatment room by his or herself, please sign here:
- Name: (print)_____
- Name: (sign)_____ Date:_____

Otherwise parent or guardian should be in treatment room during each session. Once a comfortable therapeutic relationship has been established between all parties the parent or guardian need not be in room.

- Appropriate etiquette / draping will be observed at all times during massage session.
- Client Health History is filled out and signed. I, (name) _____, am the parent / legal guardian of (child name)_____, and giver permission for my child (name) _____, age _____, to receive massage therapy from _____ therapist at Studio Zen.

Signature: _____ Date: _____ Client Name _____