MASSAGE THERAPY

DIGITAL FORMS

CLIENT NAME:

MASSAGE THERAPY

CLIENT INTAKE FORM

CLIENT INFORMATION

Name: _____ Date: _____

Occupation: _____ Age: _____ ☐ Female ☐ Male ☐ NB

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency contact: _____ Phone #: _____

Would you like to be added to our email list for news and exclusive offers? *Yes* ☐ *No* ☐

MEDICAL HISTORY

Do you have or have you had any of the following conditions? If yes, please select them:

- ☐ Arthritis / joint disorder
- ☐ Artificial joint
- ☐ Atherosclerosis
- ☐ Blood disorder
- ☐ Back/neck problems
- ☐ Cancer
- ☐ Carpal tunnel syndrome
- ☐ Circulatory disorder
- ☐ Contagious skin condition
- ☐ Decreased sensation
- ☐ Deep vein thrombosis
- ☐ Diabetes
- ☐ Easy bruising
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Fibromyalgia
- ☐ Headaches/migraines
- ☐ Heart condition
- ☐ High/low blood pressure
- ☐ Immune disorders
- ☐ Keloid scarring
- ☐ Open sores or wounds
- ☐ Osteoporosis
- ☐ Phlebitis
- ☐ Pregnant
- ☐ Recent accident/injury
- ☐ Recent fracture
- ☐ Seborrhea
- ☐ Seizure disorder
- ☐ Skin disease/lesions
- ☐ Sprains/strains
- ☐ Swollen glands
- ☐ Tennis elbow
- ☐ TMJ
- ☐ Varicose veins

Any other illness/condition: _____

Any recent surgery, including plastic surgery? ☐ No ☐ Yes: _____

MASSAGE THERAPY

CLIENT INTAKE FORM

MASSAGE INFORMATION

Have you had a professional massage before? ☐ No ☐ Yes

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

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

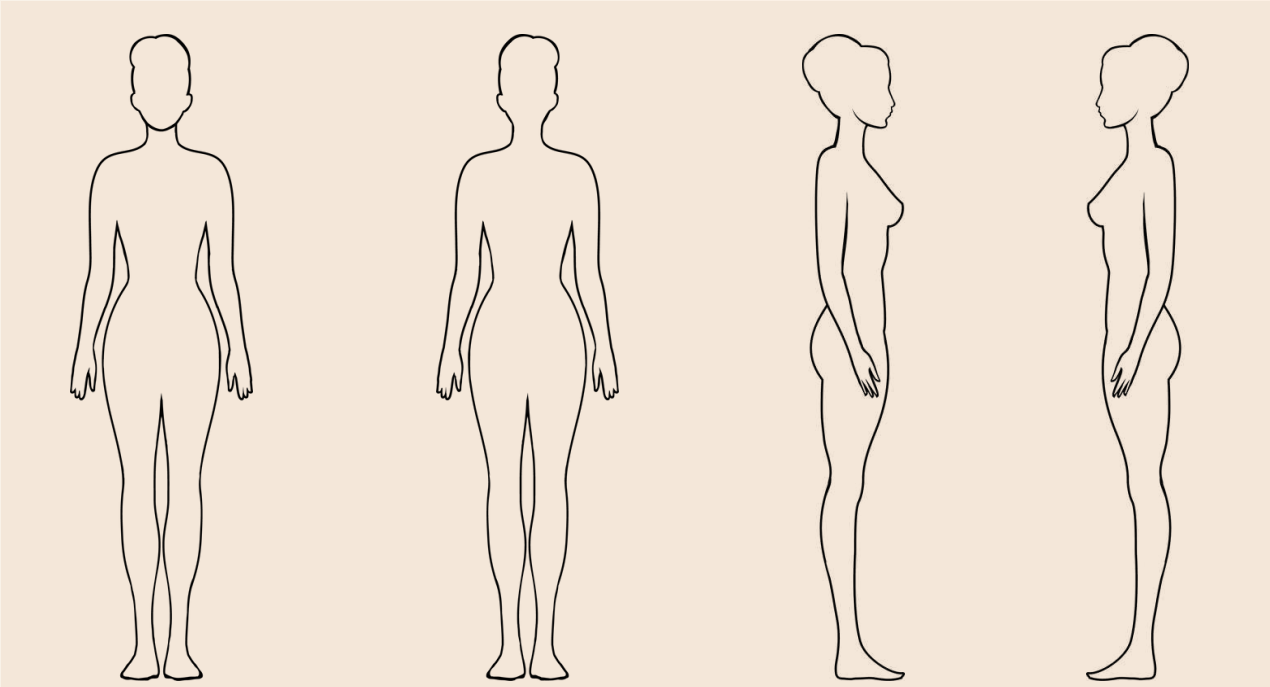
Do you have sensitive skin? ☐ No ☐ Yes

Are there any areas (feet, face, abdomen) you do not want massaged? _____

What type of massage are you seeking? ☐ Relaxation ☐ Therapeutic/deep tissue

What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep

Mark any specific areas you would like your therapist to concentrate on:



Front *Back* *Right* *Left*

By signing below, you agree to the following:
I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

_____ _____ _____

Client Name (printed) *Client Name (signature)* *Date*

MASSAGE THERAPY

CLIENT INTAKE FORM

MASSAGE INFORMATION

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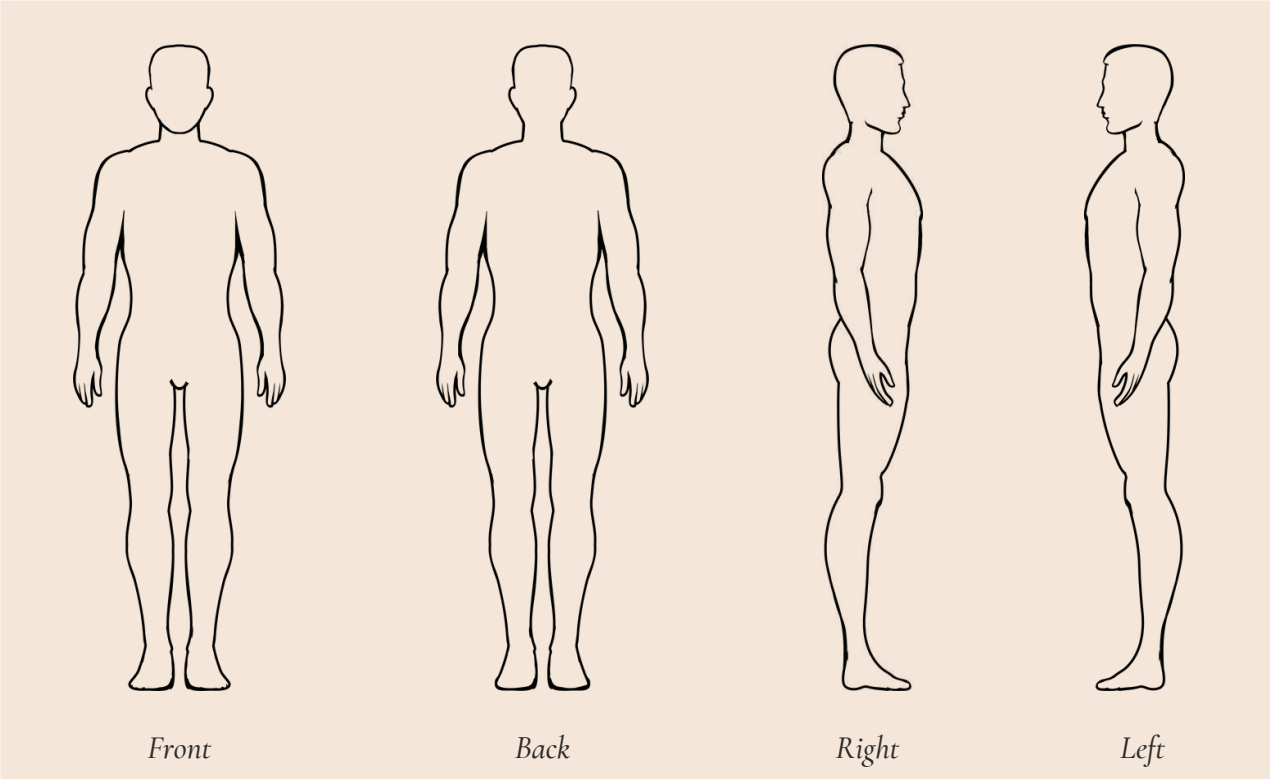

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_____ _____ _____

Client Name (printed) *Client Name (signature)* *Date*

MASSAGE THERAPY
CONSENT FORM

Client Legal Name: _____

SCOPE OF PRACTICE

Massage therapy is a profession in which the practitioner applies manual techniques, and may apply adjunctive therapies, with the intention of positively affecting the health and well-being of the client. Massage Therapists do not diagnose or prescribe for medical conditions nor are they allowed to provide treatment for a specific condition without a doctor's supervision. The massage therapist is required to refer you for diagnosis and to follow recommendations of your physician. The massage therapist are happy to adjust pressure, temperature, music volume, work longer on an area or move on if you request it.

MEDICAL CONDITIONS

It is the responsibility of the client to keep the massage therapist informed of any medical treatment currently being taken, and to provide written permission from the physician, chiropractor, physical therapist, etc., that the massage may be continued. The client must also keep the massage therapist informed of any changes in health conditions.

CONSENT

Please initial to acknowledge that you have been informed of the following:

_____ I understand that if I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

_____ I further understand that Massage Therapy 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 of which I am aware.

_____ Massage should not be performed under certain medical conditions and I affirm that I have stated all my known medical conditions, and answered all questions honestly.

Client Initials: _____

MASSAGE THERAPY

CONSENT FORM

_____ I will keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist should I fail to do so.

_____ This is a Therapeutic Massage session and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.

_____ I understand the Massage Therapist practitioner reserves the right to refuse services to me for any reason that she deems necessary.

My signature acknowledges that I have read and agree to receive the massage therapy and that I will adhere to all of the aforementioned statements that I have initialed.

_____	_____	_____
Client Name (printed)	*Client Name (signature)*	*Date*

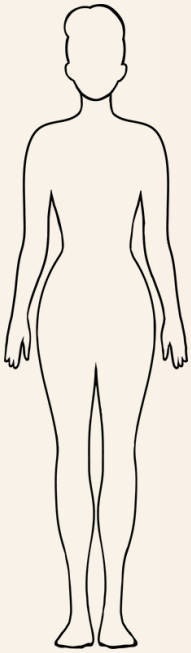
_____	_____
Therapist (signature)	*Date*

M A S S A G E T H E R A P Y

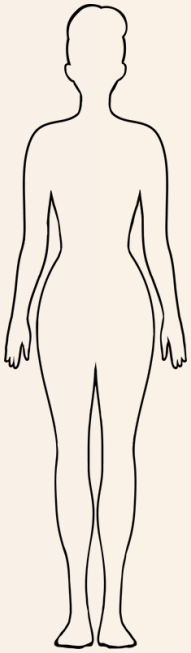
CLIENT NOTES

Name: _____ Date: _____

Date of birth: _____ Phone: _____ Email: _____



Front



Back

Right

Left

Subjective symptoms:
(Client complaints - Onset/Location/Intensity/Frequency/Aggravating Factors)

_____

_____

_____

_____

Objective findings:
(Visual assessment/Palpable/Test results)

_____

_____

_____

_____

Assessments goals:
Identify the client's condition and analyze their progress.

_____

_____

_____

_____

Plan:
(Future treatment / Frequency / Self-care)

_____

_____

_____

_____

M A S S A G E T H E R A P Y

CLIENT NOTES

Name: _____ Date: _____

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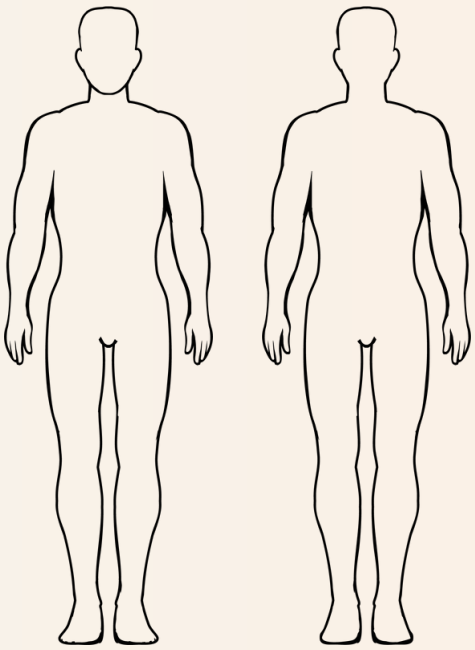
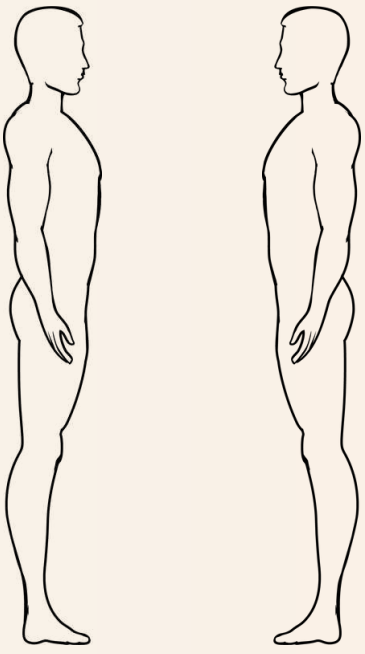


Front *Back*



Right *Left*

Subjective symptoms:
(Client complaints - Onset/Location/Intensity/Frequency/Aggravating Factors)

_____

_____

_____

_____

Objective findings:
(Visual assessment/Palpable/Test results)

_____

_____

_____

_____

Assessments goals:
Identify the client's condition and analyze their progress.

_____

_____

_____

_____

Plan:
(Future treatment / Frequency / Self-care)

_____

_____

_____

_____

MASSAGE THERAPY

PHOTOGRAPH AND VIDEO RELEASE FORM

CLIENT INFORMATION

Name: _____ Date: _____

Phone: _____ Mail: _____

I would like your permission to use these photos for advertising. For example: Portfolios, online and print ads, etc. Your consent is necessary regarding this. Please circle and indicate with your signature if you would like your photos used or not used in advertising. We also like to tag our clients in photos used on our Instagram profile! Please indicate if you'd like to allow this or not below.

- ☐ Yes, feel free to use them
- ☐ Yes please tag me on Instagram
- ☐ No, please do not use them
- ☐ No, please do not tag me

_____ _____

Client Name (printed signature) *Client Name (signature)*

_____

Date

M A S S A G E T H E R A P Y

CANCELLATION POLICY

Our goal is to provide quality care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy.

Appointments are in high demand, and your early cancellation will give another person the opportunity to have access to timely care. This policy enables us to better utilize available appointments for our clients.

At the time of booking your appointment you will be asked to pay a _____ deposit that will be credited towards your treatment/s.

Time has been specifically reserved for your appointment, procedure, or treatment. If you need to cancel or reschedule your appointment you must call at least 24 hours prior to your appointment and your deposit will either be refunded or pushed for a future appointment. However, providing less than 24 hours' notice will require you to pay a _____ cancellation fee.

If you arrive more than 15 minutes late for your appointment it is considered a no-show and you will be charged the cancellation fee.

We are happy to answer any questions regarding this cancellation policy.

I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by it's terms. I agree to pay the cancellation fee in the event of a missed appointment.

_____ _____

Client Name (printed) : *Date*

_____ _____

Client Name (signature) : *Date*