

281-367-5654

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www.massage-intouch.com

CLIENT INTAKE FORM: Please take a moment to provide me with the following information so that I may maximize the effectiveness and safety of our sessions together. All information will be kept confidential.

Client Name: _____ Today's Date: _____

Address: _____

City, State, Zip: _____ Referred by: _____

e-mail: _____

Home Phone: _____ Occupation: _____

Work Phone: _____

Cell Phone: _____ Date of Birth: _____

In the event of an emergency, please contact:

Name: _____ Relationship to Client: _____

Phone(s): _____

When did you last receive a massage? _____

Where do you have muscle pain, stiffness or tension? _____

When and how did this condition develop? _____

Is there anything that makes your condition worse? _____

What forms of exercise do you participate in? _____

MEDICAL HISTORY: Please inform me of any significant medical problems, as such conditions can influence the type and/or depth of work done in any given area.

Injury: type & date (whiplash, sprain, breaks, deep bruise, other?) _____

Auto Accident? _____ Sporting Accident? _____

Surgery: type & date _____

Are you presently taking any medications (Rx, other)? _____

PLEASE CHECK ALL OF THE FOLLOWING THAT CURRENTLY APPLY TO YOU:

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Cancer | <input type="checkbox"/> Constipation | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Edema | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hernia | <input type="checkbox"/> Herniated Disc |
| <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Numbness | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Poor Posture | <input type="checkbox"/> PMS | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Severe Menstrual Pain |
| <input type="checkbox"/> Skin Disorders | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Severe Depression | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Stomach Disorder | <input type="checkbox"/> Smoker | <input type="checkbox"/> TMJ Syndrome | <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Varicose Veins | Other, please describe _____ | | | |

Please turn over to complete this form →

CLIENT INTAKE FORM -- page two

The Massage Practitioner does not diagnose, treat, prescribe for, or offer medical service for any disease, illness, or any other physical or mental disorder of a person. It should also be clear that the service and intent of massage therapy is in no way similar to that of so-called "massage parlors".

The massage techniques employed today may include all or some of the following:

Swedish massage; sports massage techniques and stretches; trigger point therapy; deep tissue massage and/or myofascial release techniques.

I understand that I will be draped with a sheet at all times during my massage. The following body areas may be massaged: head, face, neck, arms, hands, legs, feet, back, gluteus (buttocks). Breast massage will not be a part of this massage session. Abdominal massage will only be a part of this session if requested.

I understand that if there is any part of my body that I DO NOT want massaged, it is my responsibility to state it now. Please make note here of any areas of contradiction, or personal desire to avoid:

I understand that I am responsible for communicating any physical or emotional discomfort, if any should arise, during the massage session. If I am uncomfortable for any reason, I may ask Sherry to cease the massage and she will comply.

CANCELLATION POLICY:

- A 24-hour notice is required for cancellation of an appointment to avoid paying a cancellation fee equal to the cost of the cancelled session. With the exception of sudden illness or emergency, the cancellation fee needs to be paid in full when there is a less than a 24-hour notice of cancellation.
- A no-show requires full payment of the session fee.

LATE POLICY:

- Bodywork sessions begin and end on time.
- Clients arriving thirty (30) minutes late, or later, pay full price for the session and may choose to take the abbreviated session or schedule next session.
- Clients arriving less than thirty (30) minutes late will pay full price for the session and will receive abbreviated session only.

These policies are necessary in allowing the client to get the most out of the session, as well as respecting time of the therapist and all other clients. Thank you for your understanding and compliance.

Client Signature: _____ Date: _____

Massage Therapist Signature: _____