SIMPLY THERAPEUTIC

INTAKE FORM

Name:_____ Address:_____

_____ Cell phone number:_____

Email :_____ Occupation:_____ Date of Birth:_____

Referred by:_____ May I thank them for the referral? _____ yes _____ no

Have you had a professional massage before? _____ If yes, what kinds? _____
_____

What brings you in today? What are your expectations for treatment?_____
_____

If you are in pain or have discomfort, how long have you been experiencing it? Where do you feel it?
_____

Please mark if past or present:

_____Diabetes	_____Autoimmune disease	_____Pacemaker
_____Concussion(s)	_____Arthritis	_____Disc issues
_____Osteoporosis	_____Pregnancy	_____Seizures
_____Fibromyalgia	_____Cancer	_____High blood pressure
_____Varicose veins	_____Anxiety	_____Depression
_____Whiplash	_____Trauma/PTSD	_____Allergies

Please list additional health conditions AND past accidents, injuries, surgeries and location of scars.
_____
_____
_____

Do you grind your teeth or clench your jaw? When?_____

Do you get headaches? How frequently? Where do you feel them? _____
_____

Medications being used and reason for use:_____
_____

Client signature:_____ Date:_____

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Consent for Treatment

Please initial at each statement after reading to indicate acceptance.

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

I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware._____

I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such._____

Information exchanged during any session is educational in nature and is intended to help me become more familiar and conscious of my own health. This information is to be used at my own discretion._____

I am aware that my symptoms may fluctuate in response to treatment. The practitioner does not guarantee results. _____

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

I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. Understanding all of this, I give my consent to receive care._____

Policies

Please initial at each statement after reading to indicate acceptance.

I understand that my appointment is time reserved especially for me, therefore I am responsible for a fee equivalent to session booked or forfeiture of package session for each missed or cancelled appointment without 24-hour notice._____

I understand that being late to my appointment may reduce the length of my session and that I am financially responsible for the original appointment length._____

Balance for missed appointments must be paid in full prior to scheduling of any future appointments._____

Any inappropriate or sexually suggestive comments or actions made by me, the client, will result in immediate termination of the session and I am responsible for full payment._____

Client signature _____ Date_____