

Heavenly Hands Massage Intake Form



Name _____ Date _____

Address _____
Street City State Zip

Date of Birth _____ Email: _____ Cell Number: _____

Emergency Contact _____
Name Relationship Phone Number

Are you presently taking any medication? ___ Yes ___ No

Please Explain:

Have you had a recent major surgical procedure or injury? ___ Yes ___ No

Please Explain:

Are you currently seeing a Chiropractor, Physical Therapist, or Physician for an ongoing issue? ___ Yes ___ No

Please Explain:

Is there a specific area of the body where you are experiencing tension, stiffness, pain or discomfort?

___ Yes ___ No If yes, please explain:

Do you have any allergies? ___ Yes ___ No

Please Explain: _____

How did you hear about me?

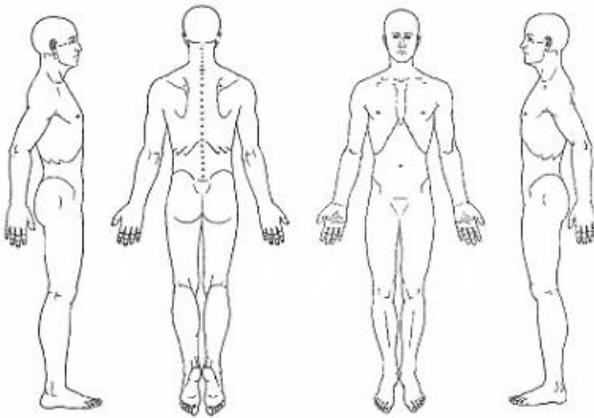
Intake Form

Please check the following conditions that apply to you, past and present. Please add any comments to clarify the condition.

Abdominal Pain
 Allergies
 Arthritis
 Blood clots
 Carpal tunnel
 Chest pain
 Circulatory Disorder
 Contagious disease
 Constipation
 Diabetes

Digestive disorders
 Dizziness
 Depression
 Fatigue
 Heart disease
 High blood pressure
 Insomnia
 Joint disorder
 Kidney disorder
 Liver disease

Low blood pressure
 Migraine headache
 Muscular injuries
 Respiratory disorder
 Sinusitis
 Skeletal injuries
 Skin disorder
 Spinal disorder
 Varicose veins
 Other: _____



Please shade in or mark an x on the areas that are causing you discomfort and/or pain.

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 my 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 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 that I am aware of. I understand that massage therapists are not qualified to perform 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. 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 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's signature _____ Date _____

Consent for Therapy and Waiver of Liability

The undersigned (“Client”) hereby freely consents to receipt of massage services from:

Tamara Buchanan

Licensed Massage Therapist’s Name

Client agrees as follows:

Client understands and agrees that they will provide the Therapist with complete and accurate health information and a written referral from Client’s primary healthcare provider if Client is currently receiving care or has a specific medical condition or symptoms for which Client takes medication or receives periodic evaluations or treatment. Client understands that massage therapy is designed to be an ancillary health aid and is not suitable for primary medical treatment for any condition.

1. Client and Therapist have discussed the potential benefits and possible side effects of massage therapy and have agreed upon a course of focused attention and therapy for the predetermined goals of stress reduction, relief of muscular discomfort, and/or promotion of general health. Client has been given an opportunity to ask questions of the Therapist and has received all requested information.
2. Client understands that the unclothed body will be draped at all times for warmth, sense of security, and as a mark of massage therapy professionalism. Client agrees to immediately inform the Therapist of any unusual sensation or discomfort so that the application of pressure may be adjusted to Client’s level of comfort. Client understands that massage therapy is not sexual in any manner and that any illicit or suggestive remarks or behavior on the client’s part will result in an immediate termination of the therapy session. Client understands that payment will be expected in full; regardless if the massage is completed or not.
3. Client hereby assumes full responsibility for receipt of the massage therapy, and releases and discharges Therapist from any and all claims, liabilities, damages, actions, or causes of action arising from the therapy received hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the Therapist, to the fullest extent allowed by law.
4. Client, in signing this consent for Therapy and Waiver of Liability (“Consent”), understands and agrees that this Consent will apply to and govern the current and all future therapy sessions performed by Therapist

Client Signature

Client Printed Name

Date

Massage Therapist Signature

Massage Therapist Printed Name

Date