CLIENT INTAKE FORM

PLEASE PRINT CLEARLY

Living Light
MASSAGE

Today's Date____________________

First______________________________________ Last ________________________________

Address ____

City ____State _________ Zip _________

Phone: Mobile____________________Home _____________________Work ____________________

Occupation ____

Email ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

❑ Yes, I would like to receive special discounts and promotions. Birthdate ________/________/________

In our efforts to promote massage and reach new clients, could you please tell us how you heard about us?

Referral: ❑ Family ❑ Friend ❑ Doctor ❑ Hotel ❑ Business Please specify____________________________

Other: ❑ Website/Online Search ❑ Drive By/Sign ❑ Social Media ❑ Gift Card ❑ Phonebook

❑ Advertisement: ____

❑ Event: ____

Have you received a professional massage in the past? ❑ Yes ❑ No

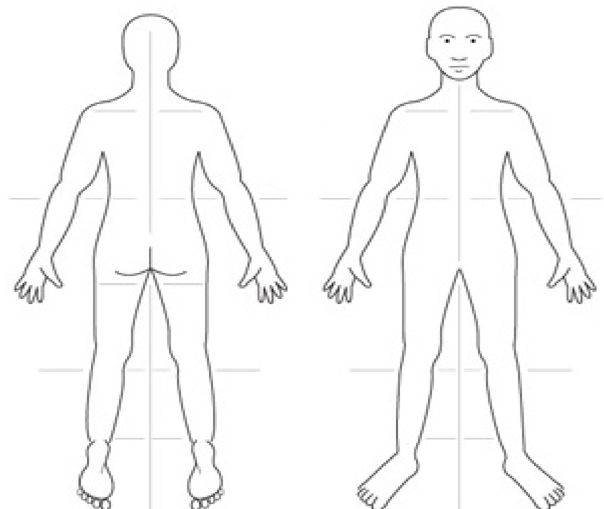
If yes, was your experience pleasant? ❑ Yes ❑ No If not, why?_____________________________________

If yes, when was the approximate date of your last massage?_______________________________________

What is your massage pressure preference? ❑ light ❑ medium ❑ deep ❑ combination

What are your common areas of pain or tension?

Please circle on chart.



Please list any areas to be avoided:

____

____

FORM CONTINUED ON BACK ➔

Do you have any allergies and/or skin sensitivities? If yes, please specify ____________________

____

____

Are you taking any medications, non-prescription drugs or supplements? Please check all that apply:

❑ Prescription skin cream ❑ Transdermal patches ❑ Aspirin ❑ Motrin/Ibuprofen/Tylenol ❑ Herbs ❑ Vitamins

❑ Diuretics ❑ Antibiotics ❑ Pain medicine ❑ Heart medicine ❑ Blood thinners ❑ Allergy medicine

Please list any medications you are currently taking____________________

____

____

<u>Please check all current or past conditions that apply:</u>

❑ Neck or back injuries
❑ Headaches or migraines
❑ Bulging or herniated discs
❑ Seizures
❑ Arthritis
❑ Cancer
❑ Skin condition
❑ Warts

❑ Heart or circulation problems
❑ High or low blood pressure
❑ Major accident
❑ Varicose veins
❑ Blood clots
❑ Implants
❑ Diabetes
❑ Fibromyalgia

❑ Numbness or shooting pains
❑ TMJ/jaw pain
❑ Recent sprains or broken bones
❑ Recent surgeries
❑ Fusions, pins or screws
❑ Contacts lenses
❑ Pregnant. If yes, how many weeks:__________

Please explain any conditions that you have marked above ____________________

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____

Have you had any major life changes recently? ____________________

____

Client Agreement:

I understand that massage therapy is provided for the basic purpose of relaxation and relief of muscle tension. Massage therapy is not a substitute for medical diagnosis and/or treatment. If I experience any pain or discomfort during the session, I will alert the practitioner so modifications can be made. Because massage therapy is contraindicated under certain medical conditions, I agree to fully disclose all of my known medical conditions and medications. I agree to keep my medical profile updated and understand that there shall be no liability on the practitioner's part should I fail to do so. I agree to consult with my physician if I have any concerns with receiving massage therapy prior to attending a massage therapy appointment. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will still be responsible for full payment of the session.

My signature also indicates my consent to the following: Failure to cancel appointments at least 24 hours in advance or failure to show up for my appointment will result in a charge of 50% of the scheduled appointment fee which will be processed on the credit card retained on file to reserve appointments. If a credit card is not available to charge, I understand that a bill will be sent to my home and agree to pay such bill.

Signature____________________ ***Date***__________

(If under 18, signature of parent or guardian)

Parental Consent for Clients Under 18: By signing above I hereby authorize the massage therapists at Living Light Massage to provide massage therapy services to my child or dependent. I also approve of any future sessions until further notice.

❑ Entered Into Database ❑ Scanned & Linked

Form Date 10/18/19