Light Hand Muscle Therapy
Client Intake Form

Client: _____

Date : _____

Thank you for allowing us to be a partner in your path to health and wellness. Please help us to better serve you by providing us with some information about you and your current state of health. All information is kept strictly confidential and is only used in assessing your treatment needs. Thanks again and enjoy your session!

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

_____ Email: _____

_____ Date of Birth: _____ In case of emergency, contact: _____

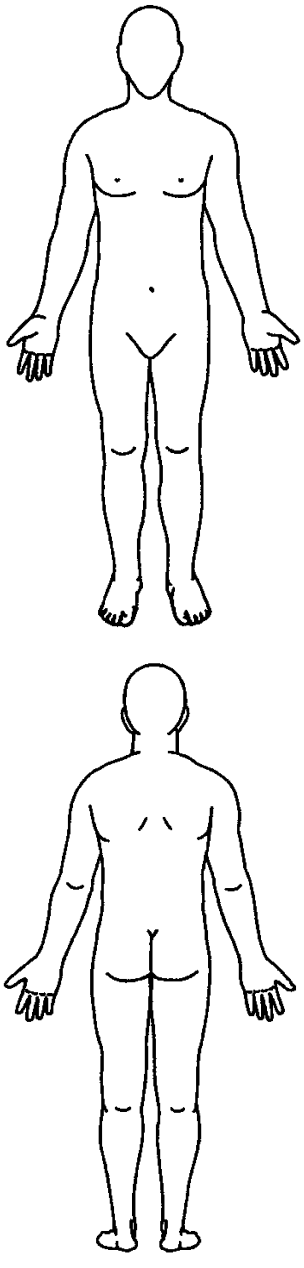
Referred by: _____ _____

- **Do you have any skin sensitivities?** O YES O NO
  If YES, please list:
- **Are you taking any prescription medications?** O YES O NO
  If YES, please list:
- Are you currently under a doctor's care for illness/injury? O YES O NO
  If YES, please explain:
- Any injuries or surgery in the past 72 hours? O YES O NO
  If YES, please explain:
- Have you ever had a major surgery? O YES O NO
  If YES please explain:
- Have you ever received therapeutic body-work before? O YES O NO
  If YES, how was your experience?
- What are your reasons for today's visit?
  (Pain relief, rehabilitation, physical stress, emotional stress, etc.)
- What is your occupation?
- What type of exercise do you do?

Circle all that apply (Please include **current and past** medical history):

Active Herpes	**Current Pregnancy**	**Heart Disease**	**PTSD**
Allergies	**Depression**	**Hepatitis**	**Rashes/Eczema**
Aneurism	**Diabetes**	**High Blood Press.**	**Rheumatoid Arth.**
Angina	**Diarrhea**	**Irritable Bowel**	**Sciatica**
Asthma	**Disk Disease/Bulge**	**Kidney Disease**	**Scoliosis**
Anxiety	**Dizziness/Vertigo**	**Low Blood Pressure**	**Shingles**
Athlete's Foot	**Diverticulitis**	**Lymes Disease**	**Sinus Infections**
Blood Clots	**Emphysema**	**Migraines**	**Spinal Cord Injury**
Bursitis	**Endometriosis**	**Multiple Sclerosis**	**Strain/Sprain**
Cancer_____	**Epilepsy**	**Numbness/Tingling**	**Stroke/TIA**
Carpal Tunnel Syn.	**Fybromyalgia**	**Osteoarthritis**	**Surgery_____**
Conjunctivitis	**Gout** □	**Osteoporosis**	**Ulcerative Colitis**
Constipation	**Headaches**	**Parkinson's Dis.**	**Varicose Veins**
Crohn's Disease	**Heart Attack**	**Pelvic Inflam. Dis.**	**Whiplash**

Please circle any problem areas on these diagrams:



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POLICIES

- 24 hour notice is required for cancellations. You will be charged for the appointment in full if notice is not given.

- Promptness is expected. If you are late, please call to warn us of a delay and we will try to work with you. If you are late, please note that we will wait 15 minutes for a client who has not called to warn of a delay. If you arrive after the start time of your appointment, the therapist will perform the massage in the remaining time but, you will be charged the full price.

FEES

Staff:	**1/2 hour…..$30**
	1 hour…….$60
	90 min……$90
Connie:	**1/2 hour…..$35**
	1 hour…….$65
	90 min……..$95
Theresa:	**1/2 hour…..$40**
	1 hour…….$70
	90 min…..$100

CONSENT FOR TREATMENT

- I understand that massage and bodywork therapy is not a substitute for primary medical care delivered by my physician or primary health care provider and that it is not within the scope of practice of the massage therapist to examine, diagnose, or prescribe medications for treatment of medical illness and injury.
- I understand that massage and bodywork is contraindicated in some medical conditions and agree to inform the therapist of any such conditions and to obtain a physician's order for massage when necessary.
- I understand that my medical information that I have voluntarily provided is truthful and accurate to the best of my knowledge and I agree to update this information as needed.
- I understand that my medical information is kept confidential and is used only for the assessment of massage and bodywork treatment needs.
- **I understand and agree to adhere to the 24 hour cancellation policy.**
- I understand that inappropriate behavior or comments of a sexual nature will not be tolerated.
- I understand that appropriate draping techniques of breasts and private areas are required by state regulation and ethical code and will be observed by the therapist at all times.
- I understand that I have the right and ability to communicate anything that causes me discomfort or concern.
- I agree to release from liability Light Hand Muscle Therapy Center for injury to myself as the result of my failure to provide accurate, current, health information to the Center or therapist.
- By signing, I consent to receive therapeutic body work from Light Hand Muscle Therapy.

Client Signature _____ Date _____