# Alcaraz Therapeutic Massage

# Client Intake and Consent Form

Maria A. Foster, LMP LIC# MT139878 — *You will be in good hands*

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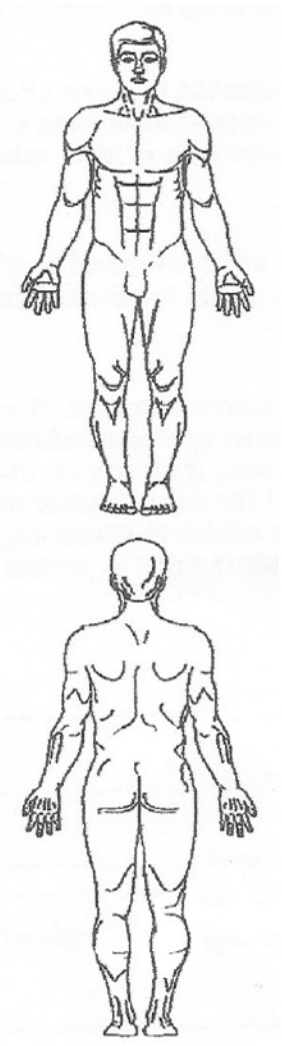
massagebook®

Please indicate areas of tension, pain or stress you are currently experiencing on the figures below.



Mark your discomfort level on this scale:

Describe discomfort:

☐Mild ☐Moderate ☐Disabling
☐Constant ☐Occasional ☐Rare
☐Chronic ☐Recurring ☐Recent/new
☐Worsening ☐No change ☐Improving

What has your treatment been?

Date:

Name: Date of Birth:

Address:

City: State: Zip:

Home Phone: Cell: Work:

Email:

How did you hear about us?

Occupation:

If you nave conditions requiring consultation with your doctor, please include their name and number:

Physician: Phone: Permission to contact:

Have you ever received a professional massage? Yes☐ No☐ How recently?

What are your massage goals?

How much pressure do you normally prefer ☐ Light ☐Medium ☐Firm ☐Not Sure

Please indicate any areas you do NOT wish to have massaged:

☐ face ☐ head ☐ neck ☐ chest ☐ abdomen ☐ back
☐ arms ☐ pelvis (not genitals) ☐ buttocks ☐ thighs ☐ Legs ☐ fee

For any of the following to which you answer Yes, please explain as fully as possible in the comments.

Yes☐ No☐ Do you have a flu or fever?
Yes☐ No☐ Do you have diabetes?
Yes☐ No☐ Do you have frequent headaches?
Yes☐ No☐ Are you having trouble sleeping?
Yes☐ No☐ Do you suffer from frequent stress?
Yes☐ No☐ Do you suffer from arthritis?
Yes☐ No☐ Do you have osteoporosis?
Yes☐ No☐ Do you have any skin conditions?
Yes☐ No☐ Do you have varicose veins?
Yes☐ No☐ Do you have any contagious diseases
Yes☐ No☐ Do you have allergies?

Yes☐ No☐ Do you suffer from seizures?
Yes☐ No☐ Any broken bones in past 2 years?
Yes☐ No☐ Any surgery/accident in past 2 years?
Yes☐ No☐ Any surgery/accident in past 24 hours?
Yes☐ No☐ Have cardiac or circulatory condition?
Yes☐ No☐ Ever been diagnosed with cancer?
Yes☐ No☐ Do you suffer from back pain?
Yes☐ No☐ Do you have numbness/stabbing pain?
Yes☐ No☐ Are you touch sensitive in any areas?
Yes☐ No☐ Do you have high/low blood pressure or take blood pressure medication?

Comments other conditions:

List any medications you are currently taking and the conditions they address:

List activities/exercise/hobbies you regularity participate in, including frequency:

Any additional information you feel the therapist should know:

**POLICIES**
Please take a moment to carefully read the following information and sign where indicated.

**EXPECTATIONS**
A massage therapy session is an experience jointly created by the therapist and the client. Working together, massage encourages stress relief and body awareness. Your therapist will listen and respond to your words and to the tissues in your body to create a safe, healthy and supportive experience. AU sessions are client-centered - your comfort and well-being is the highest priority. If you experience any pain or discomfort during the session, you will immediately inform the therapist so that the pressure and/or stokes may be adjusted to your level of comfort You agree to keep the therapist updated as to any changes in your medical profile and understand that there shall be no liability on the practitioner's part should you fail to do so.

**APPOINTMENTS AND CANCELATIONS**
Please be on time for your appointment Cancelation is expected 24 hours in advance for both client and therapist. If you provide less than 24 hours notice, and we are unable to fill you appointment time you may be responsible for the fee. if you are late you will receive only the amount remaining of your scheduled appointment.

**ALCOHOL, DRUGS AND OTHERISSUES**
A client's use of alcohol and other drugs diminishes the ability of the therapist to achieve desired results and may be cause to terminate the session. Any behavior that might be interpreted as sexual in nature is cause to terminate the session. Cancelation policy applies.

**REFERRALS**
if you have a specific medical condition or specific symptoms, massage may be contraindicated. If you are experiencing a condition that contraindicates massage, you may be referred to another appropriate healthcare provider. Massage should not be construed as a substitute for medical examination, diagnosis or treatment and you should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment you are aware of. The therapist will not diagnose, prescribe drugs or give advice to clients regarding their medical conditions. Referral from your primary care provider may be required prior to service being provided.

**PRIVACY**
All client information is held strictly confidential except where required by law.

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Client Signature: _____ Date: _____

Emergency Contact: _____ Phone: _____

Consent to Treatment of Minor: By my signature below, I hereby authorize to Alcaraz Massage to administer massage/bodywork to my child or dependent as they deem necessary.

Signature of Parent/Guardian: _____ Date: _____