CLIENT INTAKE AND CONSENT FORM

Date: ______________________

Name: ______________________ Date of Birth: ______________________

Address: ______________________

City: ______________________ State: __________ Zip: __________

Home Phone: ______________ Cell: ______________ Work: ______________

Email: ______________________

How did you hear about Om Land Massage? ______________________

Occupation: ______________________

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

Physician: ______________ Phone: ______________ Permission to contact: ________ *initials*

Have you ever received a professional massage? ☐ No ☐ Yes 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 ☐ feet

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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: ______________________________

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

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

____

Any additional information you feel the therapist should know: ______________________

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(over)

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. All 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 CANCELLATIONS

Please be on time for your appointment. Cancellation 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 OTHER ISSUES

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. Cancellation policy applies.

REFERRALS

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

PRIVACY

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

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Client Signature: ______________________________ Date: ______________

Emergency Contact: ______________________________ Phone: ______________

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