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GENERAL INTAKE FORM & MASSAGE CONSULTATION DOCUMENT

Name _____ DOB _____

Address _____ City/State/Zip _____

Email _____ Consent to contact by email: Y N

Occupation _____ How Long _____

Emergency Contact: _____ Relationship _____

Contact Number _____ (c) (w)(h)

Primary Physician _____

How did you hear about us? _____

MEDICAL HISTORY

Medications & supplements, please list name and use: _____

Are you pregnant? yes no If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? yes no If yes, please explain: _____

What makes it better? _____

What makes it worse? _____

Broken Bones yes no If yes, please list: _____

Surgeries, within the past 5 years (please indicate year):

Have you been in a motor vehicle accident? Yes No If yes, mo./yr. _____
injuries _____.

Please indicate any of the following that apply to you	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Sprains or Strains
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Broken Bones
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> TMJ Dysfunction
<input type="checkbox"/> Diabetes: Type 1 ___ Type 2 ___	<input type="checkbox"/> Gout
<input type="checkbox"/> Joint Replacement(s)	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Neuropathy, where: _____	<input type="checkbox"/> Stress high <input type="checkbox"/> low <input type="checkbox"/> medium <input type="checkbox"/>
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Stroke	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Constipation
<input type="checkbox"/> Stroke	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Circulatory Condition
<input type="checkbox"/> Kidney Dysfunction	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Defibrillator
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Numbness, where: _____	<input type="checkbox"/> Spinal problems
	<input type="checkbox"/> Bruise Easily
	<input type="checkbox"/> PTSD
	<input type="checkbox"/> PTSS

Have you had professional massage therapy before? yes no

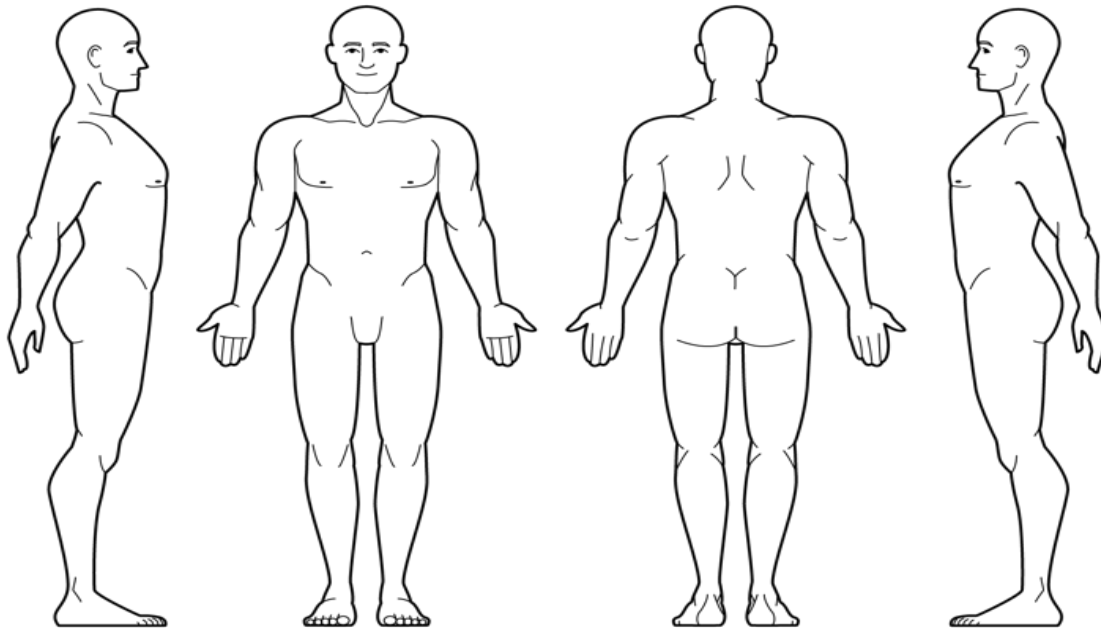
Reason for today's visit? Relaxation Therapeutic Other: _____

Type of massage therapy you are requesting: Swedish/Relaxation ___ Cupping ___

Hot Stone _____ What pressure do you prefer? Light Medium Firm

Sensitivity to pressure or touch on the feet or elsewhere on the body?

Please circle areas of discomfort/pain. To indicate your level of pain/discomfort, place corresponding discomfort or pain level number from 0-5 next to area(s) circled: (0=nothing; 1=mild (I can ignore it); 2=moderate (it's getting my attention); 3=severe (make it stop); 4=extremely painful (I'm about to scream); and 5=excruciating (there are no words)).



The licensee will drape the breasts of all female clients. Licensee does not provide breast massage. Draping of the genital area and gluteal cleavage will be used at all times during the session for all clients.

If the client is uncomfortable for any reason, the client may ask the licensee to end the massage and licensee will end the session. The licensee also has a right to end the session if uncomfortable for any reason.

CANCELLATION POLICY: Client must provide 24-hour notice to cancel an appointment. Failure to provide 24 hours notice will result in you being charged for the entire session.

By signing below, you agree that: I will comply with the Cancellation Policy; and that I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client's Signature _____ Date _____

Therapist's Signature _____ Date _____

Guardian's Signature _____ Date _____

THE FOLLOWING SECTION TO BE COMPLETED BY LICENSEE

Type of massage service/technique to be used: _____

Parts of the body to be massaged (including indications and contraindications):

Licensee's signature: _____ Date: _____

(Tyshaun Rochelle Layne, LMT 122473)