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Tyshaun R. Layne, LMT 122473 alchemymassagebodyworksa.com

GENERAL INTAKE FORM & MASSAGE CONSULTATION DOCUMENT

Name _____ DOB _____

Address _____ City/State/Zip _____

Email _____ Consent to contact by email: Y N

Phone Number _____ (Cell) (Work) (Home)

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	
☐ Cancer	☐ Sprains or Strains
☐ Headaches/Migraines	☐ Broken Bones
☐ Arthritis	☐ Insomnia
☐ Rheumatoid Arthritis	☐ TMJ Dysfunction
☐ Diabetes: Type 1 ___ Type 2 ___	☐ Gout
☐ Joint Replacement(s)	☐ Varicose Veins
☐ High/Low Blood Pressure	☐ Thyroid Disease
☐ Neuropathy, where: _____	☐ Stress high ☐ low ☐ medium ☐
☐ Fibromyalgia	☐ Fatigue
☐ Stroke	☐ Sinusitis
☐ Heart Attack	☐ Constipation
☐ Stroke	☐ Diarrhea
☐ Heart Condition	☐ Circulatory Condition
☐ Kidney Dysfunction	☐ Pacemaker
☐ Kidney disease	☐ Defibrillator
☐ Blood Clots	☐ Fibromyalgia
☐ Numbness, where: _____	☐ Spinal problems
	☐ Bruise Easily
	☐ PTSD
	☐ PTSS

Have you had professional massage therapy before? ☐ yes ☐ no

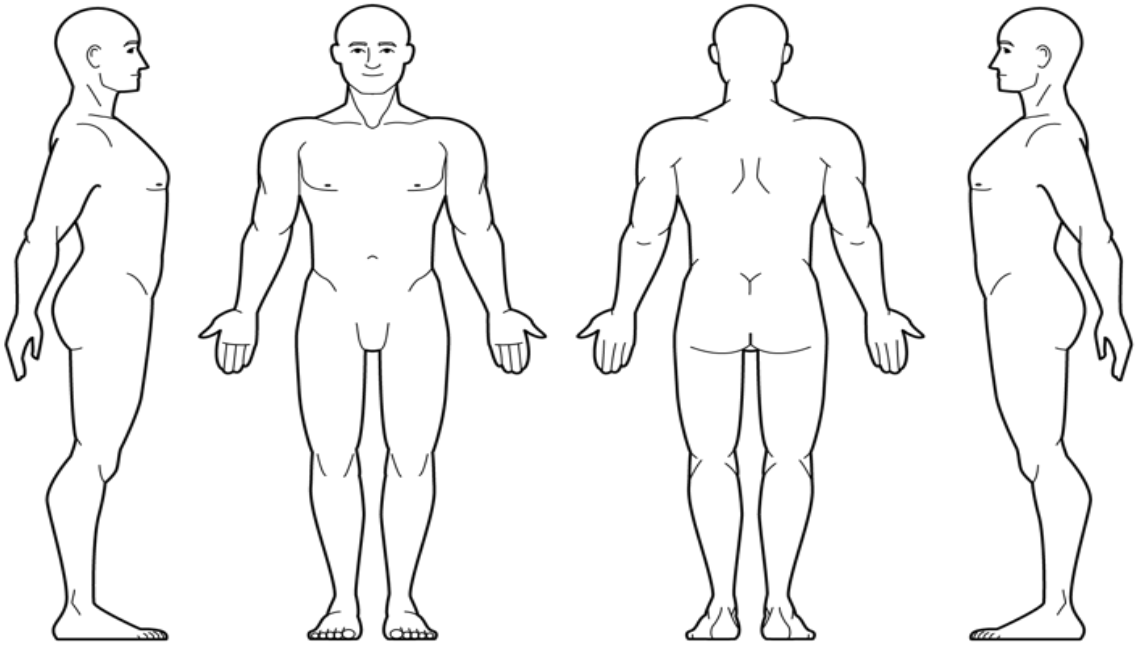
Reason for today's visit? ☐ Relaxation ☐ Therapeutic Other: _____

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 is required to provide notice no less than 24 hours prior to the scheduled appointment. Failure to provide such notice will result in being charged for the entire session.

_____ (client acknowledges cancellation policy)

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)