Confidential Information

Client Intake Form

Welcome. I want to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your visit, please let me know.

Chillax Massage

(circle one)
home
work
cell

Name: _____ **Phone:** _____

Street: _____ **City:** _____ **State:** _____ **ZIP:** _____

Date of Birth: _____ **Age:** _____ [ ] Male [ ] Female **Marital Status:** _____

Referred By: _____ **Occupation:** _____

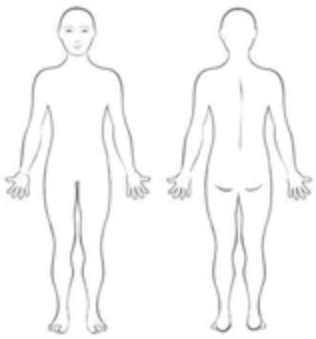
Email Address: _____

HAVE YOU EVER RECEIVED MASSAGE THERAPY? [ ] No [ ] Yes If yes, what type of massage have you experienced?
[ ] Deep Tissue [ ] Swedish [ ] Ashiatsu [ ] Other(s) _____

DO YOU HAVE ANY OF THE FOLLOWING TODAY?

[ ] sunburn
[ ] inflammation
[ ] severe pain
[ ] headache

CIRCLE AREA OF PAIN



WHAT TYPE OF TOUCH DO YOU PREFER?

[ ] light/meditative
[ ] heavy/invigorating
[ ] deep/trigger point

PLEASE CHECK IF YOU HAVE, OR HAVE HAD, ANY OF THE FOLLOWING CONDITIONS:

[ ] skin condition (acne, rash, skin cancer, other)
[ ] lymphatic condition (swollen glands, lymphoma, other)
[ ] recent injury (whiplash, sprain, deep bruise, other)
[ ] recent knee or hip injury
[ ] recent injections at a joint or muscle juncture (cortizone, Botox)
[ ] circulatory condition (heart disease, high blood pressure, varicose veins, arrhythmia,thrombosis, arteriosclerosis, pacemaker, stint or shunt)
[ ] boils or abscesses
[ ] diabetes
[ ] low blood sugar
[ ] aneurysm
[ ] irritable bowel syndrome
[ ] kidney disorder
[ ] joint stiffness or joint pain
[ ] tendency for headaches
[ ] dislocation of shoulder
[ ] pregnancy or trying to get pregnant
[ ] heavy or unusual menstrual flow
[ ] breast or any other implants within the last year
[ ] bone condition (osteoporosis, rib fracture, cancer, other)
[ ] neurological condition (sciatica, numbness/tingling, stroke, epilepsy, other)
[ ] emotional condition (depression, anxiety, other)
[ ] previous surgeries (please state date and type)

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS:

[ ] Coumadin [ ] Lavonox [ ] Heparin [ ] heavy Aspirin [ ] Other(s) _____

NAME OF HEALTH CARE PROVIDER (DOCTOR) _____ **PHONE:** _____

YOU HAVE MY PERMISSION TO CONTACT MY HEALTH CARE PROVIDER SHOULD THE NEED ARISE:

CLIENT SIGNATURE: _____ **DATE:** _____

Policies and Consent Agreement

Chillax Massage makes every effort to make sure you have a great massage, and we thank you for entrusting us to take the best possible care of your wellness needs.

Appointment Cancellation Policy

By signing, you agree to Chillax Massage's cancellation policy, which requires a 24-hour notice to cancel any appointment. In the event of a late-cancellation or no-show, you will be charged 50% of the scheduled service price.

Please arrive at least 10 minutes prior to your appointment in order to enjoy a complete massage session. Late arrivals may cause a massage service to be shortened.

CLIENT SIGNATURE: _____ **DATE:** _____

Informed Consent

I understand that the massage given to me by Chillax Massage is for the purpose of stress reduction, relief from muscle tension, increasing circulation, and general relaxation. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes can be adjusted to my level of comfort.

I understand that the massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.

I understand that massage therapy is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have.

I understand that I may experience possible side effects, such as sinus congestion, stiffness or soreness, headaches, or bruises. Because massage should not be performed under certain adverse conditions, I affirm that I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes.

I understand that payment is due at the time of treatment.

CLIENT SIGNATURE: _____ **DATE:** _____