Abundant Life Therapies

New Client Intake Form

Name _____ DOB _____ Male / Female

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

Email _____

Emergency Contact
Name _____ Phone _____ Relation _____

How did you hear about us? _____

Physical Activities/Hobbies _____

Massage History

Have you ever received a professional massage? Yes / No (circle one)
If yes, how often? _____ Date of last massage _____

Depth of pressure preferred: Light Moderate Firm Deep (circle one)

Is there any particular area you would like the therapist to focus? _____
_____

Please feel free at any time to communicate to the therapist any information about the comfort or discomfort of the pressure or technique being used. It is the intent of the therapist to provide a therapeutic massage; however, either party may terminate the massage at any time, for any reason.

Medical History Do you have or have you ever had any of the following:

__ Acute Infectious Disease
__ Asthma/Respiratory
__ Bruise easily
__ Chest pain
__ Dizziness
__ Foot problems
__ Insomnia
__ Neck Pain
__ Poor circulation
__ Stroke
__ Tendonitis
__ Allergies: _____
__ Back Pain
__ Cancer
__ Diabetes
__ Earache/ear ringing
__ Heart Disease
__ Nervousness/stress
__ Numbness/tingling
__ Poor posture
__ Swollen ankles
__ Tremors
__ Arthritis:
__ Blood/Phlebitis
__ Cold/Flu
__ Disc problems
__ Headache
__ Hernia
__ Muscle cramps/spasms
__ Osteoporosis
__ Skin problems
__ Swollen joints
__ Varicose Veins

If you are female, are you pregnant? Yes / No (circle one)

Are you currently under the care of a health practitioner? Yes / No (circle one)

If yes, please explain: _____

Please list current prescription and over the counter medications and their associated condition

_____

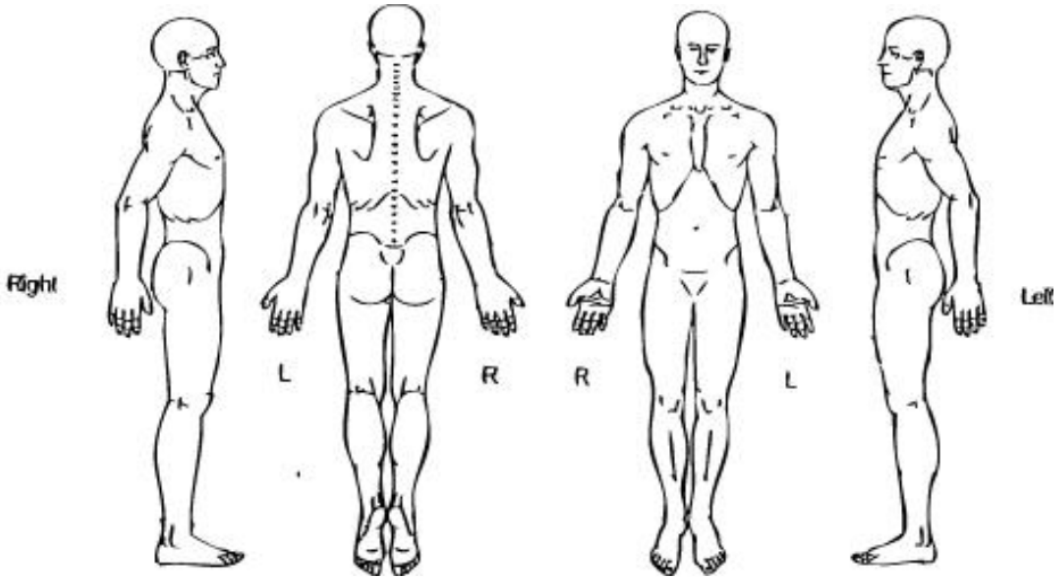
Any heart condition(s)? _____ Blood Pressure: Low / Normal / High (circle one)

Have you been hospitalized or had surgery within the past 2 years? Yes / No (circle one)

If yes, please explain: _____

Have you had any recent injury, serious illness, or are you suffering from a chronic condition? Yes / No (circle one)

If yes, please explain: _____



Which areas require extra focus? _____

_____

Which areas would you like avoided? _____

_____

The undersigned stipulates the following:

- I am solely responsible for my physical condition and for seeking medical treatment when necessary.
- I acknowledge that the intent of the massage is not to diagnose or treat illnesses.
- I further authorize Abundant Life Therapies to contact my primary health care provider for information pertaining to my health and safety regarding massage.
- I have read, or had read to me, the above information and to the best of my knowledge certify it to be true.
- I understand that if I cancel my appointment with less than 12 hour notice I will be charged a cancellation fee equaling half of the cost of the scheduled service. If I miss my appointment and or cancel on the same day of service (considered a no-show) I will be charged the full amount of the service and future appointments may require a deposit. I agree to pay this fee by cash, electronically, credit or by check payable to Abundant Life Therapies.

Signature _____

Date _____

Erin Bay Feller LMT #15644

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