FLOURISH THERAPIES
massage & skincare

Massage Therapy Client Intake & Consent Form

Name _____ Date of birth: _____

Address _____ City, State, Zip _____

Preferred Phone Number _____ Email _____

Occupation _____ Emergency Contact Name/Phone _____

How did you hear about Flourish Therapies? _____

Health Historv

Please list any prior Surgeries/Accidents_____

_____

Are you currently under a physician's care? ☐ Yes ☐ No If yes, please explain _____

Please list current medications_____

_____

Are you pregnant? Or trying to become pregnant? ☐ Yes ☐ No Are you taking birth control or HRT? ☐ Yes ☐ No

CHECK ALL THAT APPLY							
Musculo-Skeletal				**Circulatory**			
☐	Tendonitis	☐	Bone or joint disease	☐	Heart Condition	☐	Varicose Veins
☐	Broken/Fractured Bones	☐	Bursitis	☐	High Blood Pressure	☐	Low Blood Pressure
☐	Sprains/Strains	☐	Arthritis	☐	Lymphedema	☐	Breathing Difficultly
☐	Neck, shoulder, or arm pain	☐	Lower back, hip, or leg pain	☐	Sinus Problems	☐	Allergies_____ _____ _____
☐	Jaw pain/TMJ	☐	Migraines/Head injuries	☐	Hepatitis C	☐	Blood Thinners
☐	Lupus	☐	Spasms/Cramps	☐	Diuretics	☐	High Cholesterol
☐	Implants	☐	Medical Devices	☐	Pace Maker	☐	Hemophelia
☐	Metal Plates, Rods	☐		☐	Blood Clots	☐	Stents
Skin				**Nervous System**			
☐	Athletes Foot	☐	Rashes	☐	Herpes/Shingles	☐	Numbness/Tingling
☐	Warts	☐	Eczema/Psoriasis	☐	Chronic Pain	☐	Fatigue
☐	Allergies:_____ _____ _____	☐	Hives			☐	Sleep Disorders
Other				**Infectious Disease**			
☐	Cancer/Tumors	☐	Asthma	☐	Contagious Skin Disorder		
☐	Diabetes	☐	Thyroid Condition	☐	HIV/AIDS		
☐	Tuberculosis	☐		☐	Disease Name(s)_____		

Massage Health Information

Have you ever received a professional massage? ☐ Yes ☐ No If yes, frequency?_____

If yes, what did you like most?_____ What did you dislike? _____

Please check the areas of your body that you give permission to receive massage.

☐	Back	☐	Legs	☐	Buttocks	☐	Arms	☐	Abdomen	☐	Chest	☐	Neck	☐	Scalp	☐	Feet	☐	Face

Are you currently experiencing any pain? ☐ Yes ☐ No

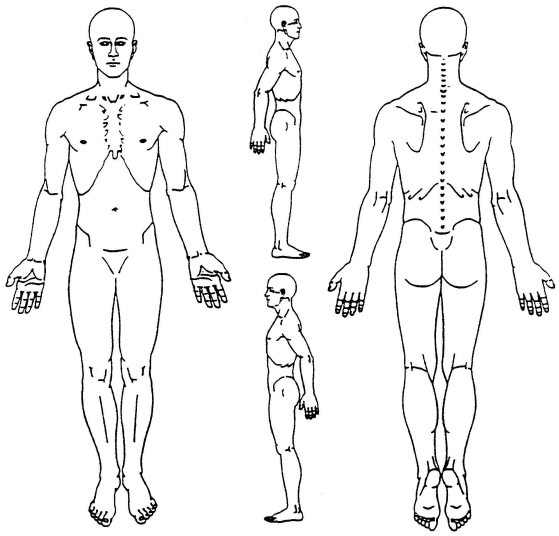
If yes, please explain_____

How long have you been experiencing this pain? _____

What makes it worse? _____

What makes it better? _____

Circle your areas of concern or complaint on the diagram below.



Is there any condition not listed above that your massage practitioner should be aware of? If yes, please list

_____

_____

Client Agreement & Policies

I have completed this form to the best of my knowledge and will inform the massage therapist of any changes in my health. I, the undersigned, understand that massage therapy and manual lymph drainage are for the purpose of stress reduction, relief from muscle tension pain, relaxation and improvement of circulation and lymphatic flow. I am aware that my massage practitioner does not diagnose health conditions, prescribe medication or perform spinal manipulations. I understand professional massage is not a substitute for medical treatment.

It is understood that any inappropriate suggestive remarks or advances will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I agree to give a 24-hour notice for a scheduled session I cannot keep. I agree to be charged 50% of the service that I do not give a 24-hour notice to cancel or reschedule. I agree that if I am late for a service I have scheduled, the therapist may subtract time from my massage as to not penalize the client that may be following my scheduled service

I hereby assume full responsibility for the receipt of massage therapy and release the therapist from all claims, liabilities or damages arising from the therapy received.

Client Signature _____ Date _____

Parent/Guardian Signature (if 18 years or younger):_____ Date _____