**Client Intake for Massage Therapy and Cupping Consent forms attached:**

**By Massage Therapist: Dana Phillips**

**DATE:**

NAME:

ADDRESS:

EMAIL:

TELEPHONE:

Occupation:

Referred By:

Date Of Birth:

Have You Had a Professional Massage or Body Treatment Before?

Primary Reason For Treatment:

Areas That Need Attention:

Have You Had any Injury and/or Surgeries?

If Yes, Please Provide Details**:**

**How Would You Describe Your General Health?**

Poor Fair Good Excellent

**How Would You Describe Your Lifestyle?**

- Dietary Habits
- Exercise Habits
- Rest/ Stress Levels
- Vitamins, Herbs and Medication

**Do You Take High Amounts of Any Of The Following?**

- Caffeine
- Nicotine
- Alcohol
- Fast Food
- Water

**Please check if you have any of the following and provide details if needed:**

- Blood Clots
- Diabetes
- Cancer
- Heart Disease/Heart Attack
- Stroke
- Joint Disease
- Skeletal Injuries
- Osteoporosis/ Degenerative Spine/Disc
- Skin Conditions
- Arthritis
- Circulatory Disorders
- High Blood Pressure
- Low Blood Pressure
- Hernia/ Rupture
- Varicose/ Spider Veins?
- Allergies/ If so what type?
- Are you allergic to scent/ aromatherapy?

**Please check any Chronic Conditions that you may be having and provide details if needed:**

- Abdominal Pain
- Dizziness
- Fatigue
- Sinusitis
- Joint Pain
- Swelling
- Bruise Easily
- Constipation
- Chest Pain
- Depression
- Insomnia
- Migraine Headaches
- Headache
- Digestive Problems
- Are Your Pregnant?

IS THERE ANYTHING ELSE THAT WE SHOULD KNOW PRIOR TO YOUR TREATMENT? FOR EXAMPLE, WHAT DID YOU MOST LIKE AND/OR DISLIKE SURROUNDING PRIOR MASSAGE THERAPY SESSIONS?

**

**CONSENT FOR TREATMENT**

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

**Client Signature:**

**Date:**

**RELEASE STATEMENT FOR RECEIVING CUPPING THERAPY FROM DANA PHILLIPS, LICENSED MASSAGE THERAPIST**

I UNDERSTAND THAT ALL TREATMENTS AT THIS FACILITY ARE THERAPEUTIC IN NATURE. I AGREE TO NOTIFY THE THERAPIST OF ANY PHYSICAL DISCOMFORT OR DRAPING ISSUES DURING THE SESSION.

THIS FACILITY HAS PROVIDED ME WITH INFORMATION SURROUNDING CUPPING THERAPY. IF I CHOOSE TO EXPERIENCE THIS THERAPY IN MY TREATMENT, I UNDERSTAND THE EFFECTS AND AFTER-CARE RECOMMENDATIONS. IT HAS BEEN EXPLAINED TO ME THAT THERE IS THE POSSIBILITY OF A SKIN DISCOLORATION, OR "**CUP KISS**," APPEARING AS TISSUE IS RELEASED**. I AM AWARE THAT A "CUP KISS" IS NOT A BRUISE AND THAT IT WILL DISSIPATE WITHIN A FEW HOURS TO A FEW DAYS.**

THIS FACILITY AND THE THERAPIST WILL NOT BE HELD LIABLE FOR INDICATIONS THAT ARISE DURING OR AFTER THE TREATMENT, AND I AGREE TO NOTIFY THE THERAPIST IF THERE IS ANY DISCOMFORT DURING A SESSION. I HAVE STATED ALL RELEVANT PHYSICAL CONDITIONS AND WILL INFORM THE THERAPIST OF ANY CHANGES IN MY HEALTH.

**Client Signature:**

**Date:**