MASSAGE THERAPY

DIGITAL FORMS

CLIENT NAME:

MASSAGE THERAPY

CLIENT INTAKE FORM

Name: _____

DOB: _____ Age: _____ ◯ Female ◯ Male ◯ NB

Phone: _____ Email: _____

Emergency Contact & Number _____

How did you hear about us? _____

Health & Medical History

Do you have any pre-existing medical conditions or chronic illnesses? Please describe. ◯ No ◯ Yes

_____

Are you currently taking any medications or supplements? ◯ No ◯ Yes

If yes, please describe _____

Have you had any recent surgeries or medical procedures? ◯ No ◯ Yes

If yes, please describe _____

Have you had any allergic reactions to medications or substances in the past? Please describe. ◯ No ◯ Yes

_____

Do you have any known skin allergies or sensitivities? ◯ No ◯ Yes

If yes, please describe _____

Massage Therapy History

Have you had any previous treatments or procedures related to massage therapy? If yes, please describe. ◯ No ◯ Yes

_____

What specific concerns or goals do you have for your massage therapy session?

_____

Do you have a history of conditions that might affect your massage experience, such as muscle tension, chronic pain, or injuries? If yes, please describe. ◯ No ◯ Yes

_____

MASSAGE THERAPY
CLIENT INTAKE FORM

MASSAGE INFORMATION

Have you ever received a professional massage before? ☐ No ☐ Yes

Do you experience any difficulty lying on your front, back, or side during treatment? ☐ No ☐ Yes

Do you have any allergies to oils, lotions, or ointments used in massage therapy? ☐ No ☐ Yes

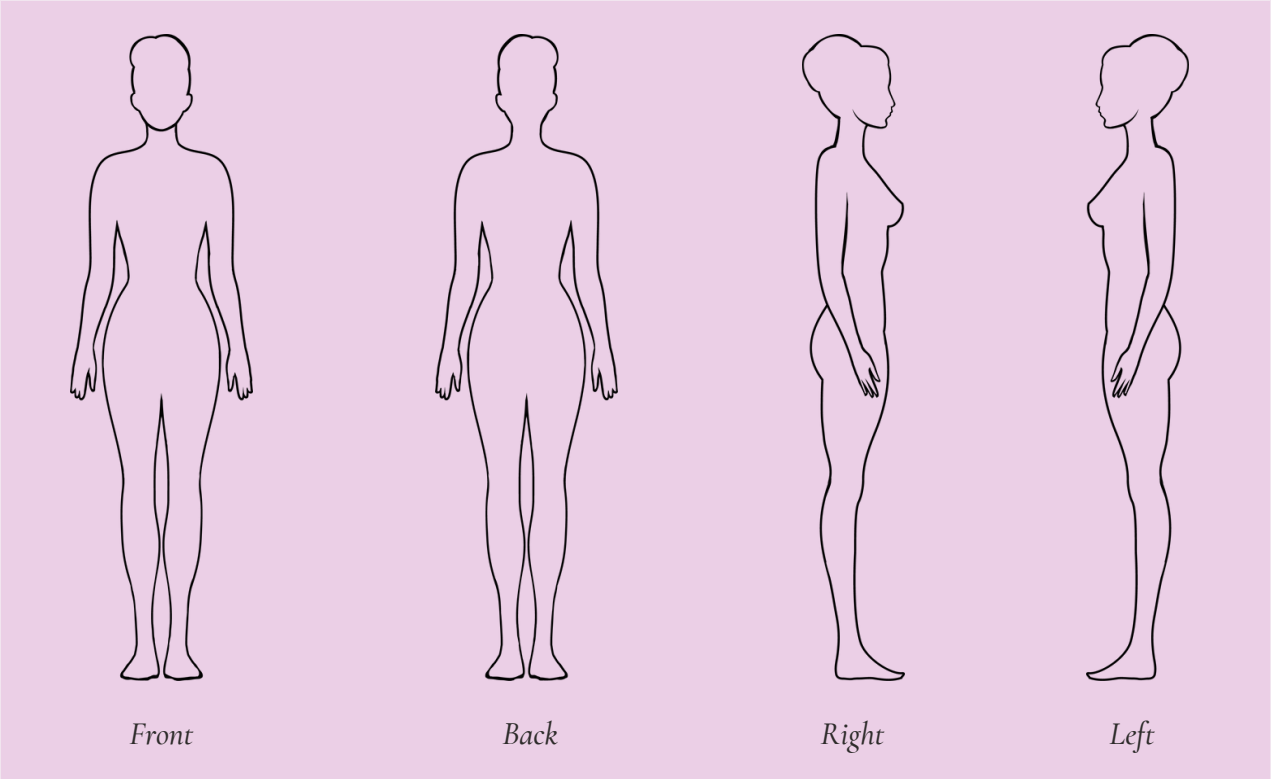
Is your skin particularly sensitive to touch or products? ☐ No ☐ Yes

Are there any areas of your body that you prefer not to be massaged? _____

What type of massage are you seeking? ☐ Relaxation ☐ Therapeutic/deep tissue

What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep

Mark any specific areas you would like your therapist to concentrate on:



By signing below, I agree to the following:

- I understand that the massage I receive is intended for relaxation and the relief of muscular tension.
- If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure or techniques can be adjusted to my comfort level.
- I affirm that I have disclosed all known medical conditions and answered all questions truthfully.
- I agree to inform the therapist of any changes to my medical history or profile.
- I acknowledge that the therapist will not be held liable for any issues arising from my failure to disclose relevant medical information.

_____ _____

FULL NAME SIGNATURE

MASSAGE THERAPY
CONSENT FORM

Client Name: _____

SCOPE OF PRACTICE

Massage therapy is a professional practice in which the therapist uses manual techniques and may incorporate complementary therapies to promote the health and well-being of the client. Massage Therapists do not diagnose or prescribe treatment for medical conditions, nor can they treat specific conditions without supervision or guidance from a physician.

If necessary, your massage therapist will refer you to a physician for diagnosis and will follow the recommendations provided.

Your comfort is a priority. The therapist is happy to adjust pressure, room temperature, music volume, spend additional time on specific areas, or move on to another area at your request.

MEDICAL CONDITIONS

It is the client's responsibility to inform the massage therapist of any ongoing medical treatments and to provide written permission from a physician, chiropractor, physical therapist, or other healthcare professional to continue massage therapy if required. The client must also promptly inform the massage therapist of any changes in their health conditions.

CONSENT

Please initial to acknowledge that you have been informed of the following:

_____ I understand that if I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure or techniques can be adjusted to ensure my comfort.

_____ I understand that massage therapy is not a substitute for medical examination, diagnosis, or treatment. For any mental or physical ailments I am aware of, I acknowledge that I should consult a physician, chiropractor, or other qualified medical professional.

MASSAGE THERAPY
CONSENT FORM

_____ I understand that massage therapy should not be performed under certain medical conditions. I affirm that I have disclosed all known medical conditions and have answered all questions truthfully.

_____ I agree to keep the therapist informed of any changes in my medical profile and understand that the therapist will not be held liable if I fail to provide updated information.

_____ This is a professional therapeutic massage session. Any inappropriate behavior, including sexual remarks or advances, will result in the immediate termination of the session, and I will remain responsible for full payment of the scheduled treatment.

_____ I understand that the Massage Therapist reserves the right to refuse services to me for any reason they deem necessary.

My signature confirms that I have read and agree to receive massage therapy. I also agree to adhere to all the statements outlined above that I have initialed.

_____ _____

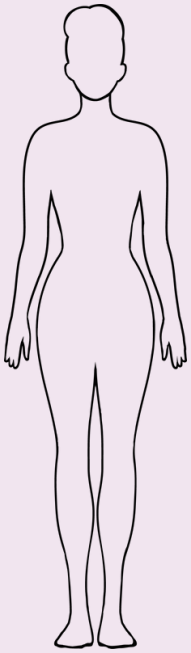
CLIENT FULL NAME SIGNATURE

Andrea C. Williams, LMT _____

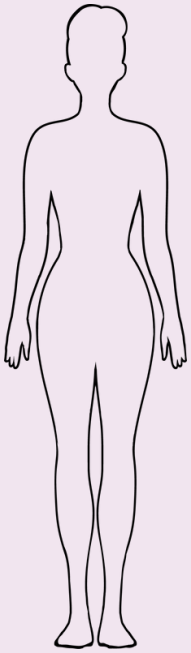
THERAPIST (SIGNATURE) DATE

MASSAGE THERAPY
CLIENT NOTES

Name: _____



Front



Back

Right

Left

Subjective symptoms:
(Client complaints - Onset/Location/Intensity/Frequency/Aggravating Factors)

_____

_____

_____

_____

Objective findings:
(Visual assessment/Palpable/Test results)

_____

_____

_____

_____

Assessments goals:
Identify the client's condition and analyze their progress.

_____

_____

_____

_____

Plan:
(Future treatment / Frequency / Self-care)

_____

_____

_____

_____

MASSAGE THERAPY

PHOTOGRAPH AND VIDEO RELEASE FORM

CLIENT INFORMATION

Name: _____

Phone: _____

We kindly request your permission to use these photos for advertising purposes, such as portfolios, online and print ads, and similar materials.
Your consent is essential for us to proceed.
Please review the options below and indicate your preference by circling the appropriate response and providing your signature.
Additionally, we love tagging our clients in photos shared on our Instagram profile!
If you'd like to allow or decline this, please let us know by selecting the corresponding option below.
Thank you!

☐ Yes, feel free to use them

☐ Yes please tag me on Instagram

☐ No, please do not use them

☐ No, please do not tag me

_____ _____

Client Signature Date

MASSAGE THERAPY
CANCELLATION POLICY

Our goal is to provide quality care in a timely manner. To ensure this, we have implemented an appointment and cancellation policy.

Appointments are in high demand, and canceling early allows another client the opportunity to access timely care. This policy helps us optimize the use of available appointments for all our clients.

When booking your appointment, you will be required to pay a $25.00 deposit, which will be applied toward the cost of your treatment(s).

Time is specifically reserved for your appointment, procedure, or treatment. If you need to cancel or reschedule, you must notify us at least 24 hours before your appointment to retain your deposit or have it applied to a future booking. If less than 24 hours' notice is provided, the deposit will be forfeited.

If you arrive more than 15 minutes late for your appointment, it will be considered a no-show, and your deposit will be forfeited.

We are happy to answer any questions regarding this cancellation policy.

I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by it's terms. I agree to pay the cancellation fee in the event of a missed appointment.

FULL NAME

SIGNATURE