Suzun Justice CMT, CLT – Client Intake Form

Client Information

Client name: _____ Date: _____

Street: _____ City: _____ State: _____ Zip: _____

(H) phone: _____ Cell: _____ Email: _____

Emergency Contact Name: _____ Phone: _____

Date of Birth: _____ Age: _____

Major body parts of concern: _____

_____

Please note any health concerns I should know about:

_____

_____

Please list any sensitivities or allergies to scents, oils or creams:

Massage & Lymphatic Therapy Consent and Release

By signing below, you agree to the following:

- I give my permission to receive massage therapy.
- I understand that therapeutic massage is not a substitute for traditional medical treatment or medications.
- I understand that the massage therapist does not diagnose illnesses or injuries, or prescribe medications.
- I have clearance from my physician to receive massage therapy.
- I understand the risks associated with massage therapy include, but are not limited to:
    I. Superficial bruising, Short-term muscle soreness and exacerbation of undisclosed injury.
        - I therefore release the business and the individual massage therapist from all liability concerning these injuries that may occur during the massage session.
- I understand the importance of informing my massage therapist of all medical conditions and medications I am taking, and to let the massage therapist know about any changes to these. I understand that there may be additional risks based on my physical condition.
- I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so she may adjust accordingly.
- I understand that I or the massage therapist may terminate the session at any time.
- I have been given a chance to ask questions about the massage therapy session and my questions have been answered.

_____ _____

Client / Guardian Signature *Date*

Hot Stone Massage and Cupping Therapies Consent and Release

Contraindications for Hot Stone Massage and Cupping therapies:

In addition to the standard contraindications for massage, hot stone massage and cupping have additional contraindications and precautions. The following is a *partial* list of common conditions to be aware of:

- Compromised immune system
- Inflammatory skin conditions
- Open wounds, sores, or thinning skin
- Hypertension
- Phlebitis / varicose veins
- Blood clot/Bleeding
- Cardiovascular disease
- Neuropathy
- Autoimmune condition (MS, Lupus, RA, etc.)
- Peripheral vascular disease
- Edema
- Blood thinning medications
- Injured areas
- Infections
- Impaired sensation

Client Release

I, _____, have read and understand the aforementioned conditions which make hot stone massage and cupping therapies contraindicated. The massage therapist has discussed this information with me and provided opportunity for any questions. I have disclosed any and all health risk factors.

Please initial the following that applies to you:

Initial_____ I understand the information contained on this form and confirm that I do not have any of these above conditions.

Initial_____ My condition(s) of _____ is/are listed above and therefore make(s) hot stone massage and cupping contraindicated. Given this knowledge, I hereby give my full consent to receive hot stone massage and/or cupping and take full responsibility of any side effects or harm that may come from my receiving these therapies.

I understand that I will be receiving hot stone massage and/or cupping as an adjunct form of healthcare only and that these therapies are not meant to replace appropriate medical care. I understand the contraindications and precautions of both hot stone massage and cupping therapies. I understand the risk of bruising and muscle soreness that may occur directly or indirectly from cupping therapy. I release the massage therapist and business of any liability for any harm that may unintentionally occur during or after my treatment(s).

_____ _____

Client / Guardian Signature *Date*

Current Medication List

Name of Patient

Please list all pharmaceuticals, vitamins and supplements you are taking. Check the appropriate box to indicate who prescribed them.

Year Started	Year Stopped	Name of Medication	For What Condition	Doctor Prescribed

ILLNESS INJURIES SURGERIES List major illness, injuries and all surgeries in your life. Include major dental work.

Incidence Approximate Age

DIET

Are you currently gluten free? If so why? _____

Do you currently adhere to a vegan, raw, vegetarian, or any other special program in your diet? If so why? _____

Do you eat a primarily organic and non GMO diet? _____

List 3 examples of each: Breakfast, Lunch, Dinner, Snacks and Beverages.

CURRENT GENERAL HEALTH INDICATORS

□ Poor Appetite □ Heavy Appetite □ Changes in Appetite

□ Disturbed Sleep □ Heavy Sleep □ Insomnia

□ Fatigue □ Localized Weakness □ Profuse Sweating

□ Poor Coordination □ Strong Thirst □ Cravings

□ Weight Gain (how much? _____) □ Weight Loss (how much?_____)

□ Cold hands □ Cold feet □ Cold Body

□ Night Sweats □ Fevers □ Chills

□ Poor Balance □ Sensitive to Tastes/Smells □ Tremors

□ Bleeding/Bruising Easily □ Ringing in Ears

HEAD, EYES, EARS, NOSE, THROAT

□ Dizziness □ Concussions □ Migraines □ Spots in front of eyes □ Night Blind □ Eye Strain

□ Cataracts □ Blurry Vision □ Ringing Ears □ Poor hearing □ Earaches □ Mucus □ Facial pain

□ Dry throat/mouth □ Sinus Congestion □ Sinus itching □ Recurrent sore/itchy throats

□ Sores on lips or tongue □ # of cavities _____ □ # of root canals _____

□ Are any of them silver/mercury amalgams? _____ □ Gum disease □ TMJ

□ Nose bleeds □ Grinding Teeth

CARDIOVASCULAR/RESPIRATORY

□ Low blood pressure □ Chest pain □ Irregular heart beat □ High blood pressure □ Fainting

□ Cough □ Cold hands & feet □ Swelling limbs □ Blood clots □ Difficulty breathing

□ Phlebitis □ Allergies □ Asthma □ Pneumonia past or present □ Anxiety Attacks

GASTROINTESTINAL

□ How often do you have a bowel movement? _____

□ Nausea □ Vomiting □ Diarrhea □ Flatulence □ Belching □ Black Stools □ Bad Breath

□ Rectal Pain □ Hemorrhoids □ Abdominal pain or cramps □ Dependence on laxatives

URINARY (MEN AND WOMEN)

□ Pain w/urination □ Frequent urination □ Blood in urine □ Urgent urination

□ Dark urine □ Difficult urination □ Kidney stones □ Decrease in flow

□ Waking at night to urinate □ Frequent bladder infections

REPRODUCTIVE/GYNECOLOGIC (WOMEN ONLY)

□ Breast pain □ Breast swelling □ Breast injury □ Breast infections □ Breast cysts

□ Suspicious lumps □ Breast cancer □ Abnormally strong underarm odor □ Yeast infections

□ Number of pregnancies _____ □ Number of abortions/miscarriage _____

□ Night sweats □ Did you breast feed? _____

□ Different breast size from right and left □ Hot flashes

□ Age of menarche _____ □ Age of menopause _____ □ Facial Hair

□ Infertility □ Hormone Replacement □ Menstrual pain

□ Emotional prior to menses □ Menstrual clots □ Heavy bleeding

□ Strong menstrual odor □ Vaginal discharge □ Birth control pill, patch, shots □ IUD

□ Tubal ligation □ Uterine Fibroids □ Hysterectomy □ Endometriosis □ Polycystic Ovaries

□ Uterine Prolapse □ Low libido □ Headaches prior to or during menstruation

□ Vaginal dryness or pain □ Painful intercourse □ Low Libido

□ Venereal Disease □ Other_____

REPRODUCTIVE (MEN ONLY)

□ Sexual Dysfunction □ Prostate Pathology □ Venereal Disease □ Hormone Imbalance

□ Infertility □ Genital Pain □ Enlarged Breasts not from muscular development

□ Painful Breasts □ Low Testosterone Levels □ Low libido □ Low Back Pain

PAIN

□ Joint Pain □ Diagnosis of Arthritis What Kind? _____

□ Muscle Pain – If so where? _____ □ Abdominal Pain

□ Nerve Pain – If so where? _____ □ Headaches

□ Do you rely on medications to be functional? _____ □ Does pain affect sleep? _____

□ Do you have an autoimmune diagnosis? _____

□ Have you ever had an autoimmune diagnosis? _____

□ Does massage or exercise help your pain? Describe. _____

_____

□ How does sleep and rest affect your pain? _____