Pure Aesthetica

Confidential Client In-Take Form (MASSAGE)

Please take a moment to carefully read/fill-out the following form and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Name: _____

Address: _____

_____

Phone # to reach you ( ) _____ - _____ ❑ Work ❑ Cell ❑ Home

Emergency Contact: _____ ( ) _____ - _____

Email: _____ Date of Birth: _____ / _____ / _____

How did you hear about us: _____

1) Reason for visit: _____

_____

2) What kind of pressure do you prefer: ❑ Light ❑ Medium ❑ Deep

3) Would you like your therapist to focus on a specific area? ❑ Yes ❑ No

Which area? _____

4) Would you like your therapist to avoid any specific area? ❑ Yes ❑ No

Which area? _____

5) Are you currently under medical supervision? ❑ Yes ❑ No

If yes, please explain: _____

6) Are you currently taking any medications or supplements (prescription and non-prescription) ❑ Yes ❑ No

If yes, name(s) of medication(s): _____

_____

7) Please check any condition listed below that applies to you: ❑ Cosmetic Fillers ❑ Implants

❑ Arthritis	❑ Diabetes	❑ Sinus Problem	❑ Skin Conditions
❑ Bruise Easily	❑ Cancer	❑ Headaches	❑ Back / Neck Problems
❑ Heart Conditions	❑ Stroke	❑ Auto-immune (AIDS, Lupus...)	❑ Allergies, Sensitivities
❑ Blood Clots	❑ Any Active Infection	❑ Chemical Dependancies	❑ Hepatitis
❑ Phlebitis	❑ Scoliosis	❑ Depression / Psych Condition	❑ High Blood Pressure
❑ Varicose Veins	❑ Chronic Pain	❑ Constipation / Diarrhea	❑ Digestive Problem
❑ Accident or Injury	❑ Recent Surgeries	❑ Muscle or Ligament Problems	❑ Pregnancy # Months _____

8) Is there anything else about your health history you think is useful for your massage therapist to know for a safe and effective massage session for you? _____

_____

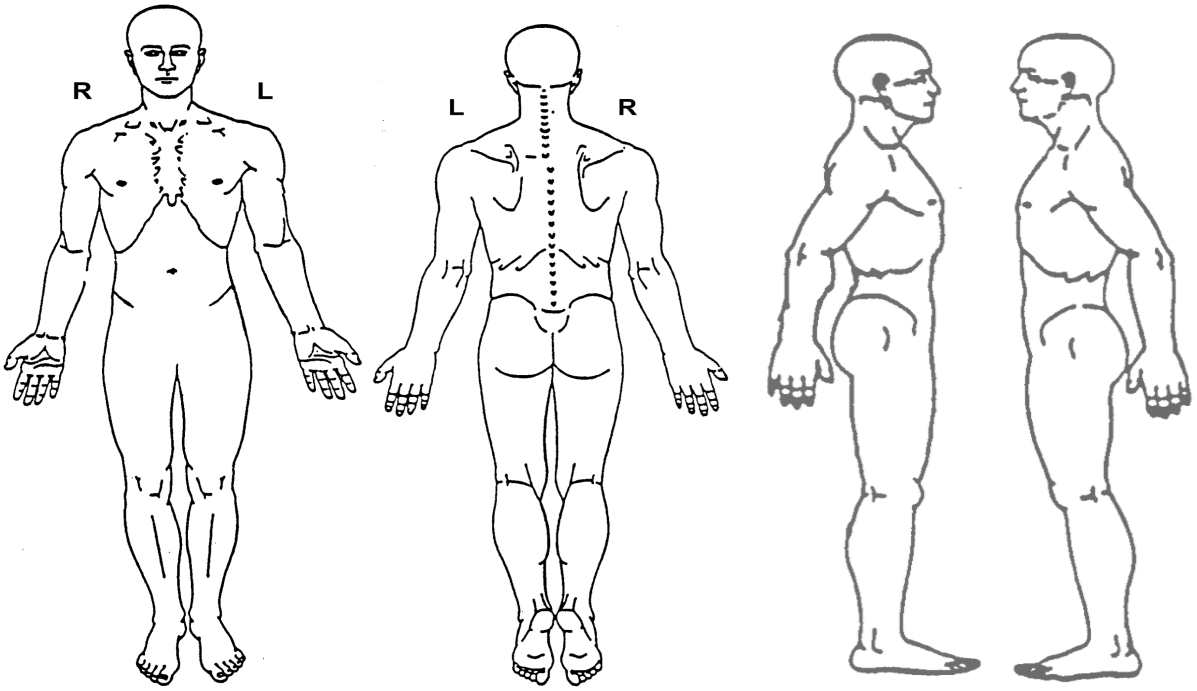
_____

(Please turn over)

9) Daily Water: _____ oz Daily Caffeine: _____ oz Weekly Alcohol: _____ oz

10) Do you follow a regular exercise program? ❑ Yes ❑ No

11) Please indicate on the diagrams any areas of concern or areas requiring special attention, and explain below.



Comments: _____

_____

_____

_____

_____

_____

The information I have provided is accurate and complete to the best of my knowledge. I understand that massage therapists do not diagnose or treat disease, and that any care or recommendation I receive from my therapist is not a substitute for a physician's care. I take responsibility for alerting my therapist of any changes to my health status, medications and therapies before the session, as well as any and all responses perceived to be a result of massage therapy as soon as I become aware of them. Draping will be used during the session – only the area being worked on will be uncovered. Informed written consent must be provided by parent or legal guardian for any client under the age of 18. I understand that no sexual activity, comment or innuendo will be tolerated. This facility reserves the right to refuse services at their discretion based upon the client's conditions, therapist's skill set, client attitude or action, etc, without explanation or prior notice, and I agree to this policy.

I give consent to this massage therapy practice for the use and disclosure of my Protected Health Information (PHI) for the specific purposes of providing treatment to me, receiving payment for services rendered to me, and for general administrative operations. I understand that I have the right to request restrictions on the use and disclosure of my PHI, but this massage therapy practice is not required to agree to these restrictions and may refuse care. If the massage therapy practice agrees with my restrictions, the restriction is considered binding. You may contact me for appointment reminders, schedule changes, or other needs.

Client Signature: _____ Date:_____

Parent or Legal Guardian Signature: _____ Date:_____