

Infinite Healing

A Holistic Mobile Spa

Massage Client Intake and Consent Form

Name _____ Today's Date _____
 Date of Birth _____ Occupation _____ Email _____
 Primary reason for service request _____
 Emergency Contact _____ Emergency Contact Phone _____

Please answer the following as they apply to you (Circle where indicated)

Have you had a professional massage before? Yes No
 Are you currently taking any medication? Yes No
 If yes, please list name(s) and reason(s) for medication(s) _____

Are you currently seeing a healthcare professional? Yes No
 If yes, please list names and reason/treatment _____

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> arthritis
<input type="checkbox"/> diabetes
<input type="checkbox"/> blood clots
<input type="checkbox"/> broken/dislocated bones
<input type="checkbox"/> bruise easily
<input type="checkbox"/> cancer
<input type="checkbox"/> chronic pain
<input type="checkbox"/> constipation/diarrhea
<input type="checkbox"/> auto-immune condition*
<input type="checkbox"/> hepatitis (A,B,C, other)
<input type="checkbox"/> skin conditions
<input type="checkbox"/> stroke
<input type="checkbox"/> poor circulation
<input type="checkbox"/> TMJ | <input type="checkbox"/> depression, panic disorder, other psych condition
<input type="checkbox"/> headaches
<input type="checkbox"/> heart condition(s)
<input type="checkbox"/> back problems
<input type="checkbox"/> high blood pressure
<input type="checkbox"/> insomnia
<input type="checkbox"/> muscle strain/sprain
<input type="checkbox"/> pregnancy
<input type="checkbox"/> scoliosis
<input type="checkbox"/> seizures
<input type="checkbox"/> whiplash
<input type="checkbox"/> varicose veins |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

*AIDS, fibromyalgia, chronic fatigue, lupus, etc.

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for a medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's or Infinite Healing's part should I fail to do so.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____