INFORMED CONSENT AND RELEASE
1. I understand if I experience any pain or discomfort during my massage therapy session, I will immediately inform the therapist so that the pressure and/or strokes will be adjusted to my level of tolerance.
2. I understand a) that the therapist is not a physician and does not diagnose illness, disease or any other physical or mental disorder; b) massage therapy is not a substitute for a medical examination and that I should see a physician for any physical or mental ailments of which I am aware; c) nor will the therapist prescribe pharmaceuticals or perform spinal or skeletal manipulations; d) no assurance or guarantee has been provided to me as to the results of the treatment; and e) that with any treatment, there can be risks and those risks have been explained to me and I assume those risks.
3. I understand the therapist must be made fully aware of my existing medical conditions. I have disclosed in the medical history section of this form all of my medical conditions that I am aware of at this time. I agree to inform the therapist of any changes in my medical profile. I hereby waive and release the therapist from any and all liability, past, present, and future relating to treatment if I fail to do so. The information provided is true and complete to the best of my knowledge.
4. I 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 full payment of the scheduled appointment.
5. I understand draping will be used during the session and only the area being worked on will be uncovered.
6. I understand that I am responsible for any charges incurred in the course of my treatment.
7. I understand that if I or my child/ward is under the age of 18, then a written consent from a parent/legal guardian is required. Any patient under the age of 16 must be accompanied by a parent/legal guardian during the entire session.
8. I understand all information pertaining to my condition(s) and/or treatment(s) to/from other caregivers or third party payers will only be done with a written request from me.
9. I understand the policy that any appointment missed or cancelled with less than 24-hour notice will be subject to 100% charge of the service scheduled to be paid prior my next appointment. This fee is monetary and may be taken from a pre-paid package or other discounted therapy service.

By signing this informed consent and release, I affirm my consent to treatment (including assessments, examinations and massage techniques) by Karen L. Salisbury, licensed massage therapist. I understand that at any time, I may withdraw my consent and treatment will end.

Check if Applicable: ___ CONSENT TREATMENT OF MINOR: I hereby authorize massage therapy/bodywork to be performed on my child/ward herein named on this intake form.

(This copy is for your records. A signed copy will be kept at Karen L. Salisbury’s office.) Date: ____________________
Massage Therapy Client Intake Form

CLIENT INTAKE (please print clearly)

Name: ___________________________________________ Date: ______/_____/_______
Address: ___________________________________________ Gender: ___ Male ___ Female
City/State: ___________________________________________ Zip: ___________________
Home Ph: ___________________________________________ Cell Ph: ___________________
Email: ___________________________________________ DOB: ______/_____/_______
Emergency Contact: ___________________________________________ Phone: ___________________

Occupation: ___________________________________________ % Sit:____ %Stand: ___ %Walking:___ %Other:___

Whom should we say “Thank You” to for referring you to our office? ___________________________________________

MEDICAL HISTORY

An accurate health history ensures that it is safe for you to receive massage therapy, and helps the therapist determine a proper treatment plan. Please keep the therapist updated as to any changes in your medical profile. All information gathered on this form is confidential. Your written authorization is legally required before any of this information can be released. Please indicate all conditions that are current (C) or you have had in the past (P).

___ Allergies ___ Emphysema ___ Inflammation ___ Serious Accident
___ Appendicitis ___ Epilepsy ___ Insomnia ___ Skin Disorders
___ Arthritis ___ Fainting ___ Lymph Edema ___ Sensitivities
___ Asthma ___ Fever ___ Migraines ___ Stiff Neck
___ Blood Clots ___ Fibromyalgia ___ Multiple Sclerosis ___ Stroke
___ Blood Pressure High ___ Fractures ___ Nervous Condition ___ Tendonitis
___ Blood Pressure Low ___ Head Injury ___ Numbness ___ Thyroid Hypo
___ Bursitis ___ Headaches ___ Osteoporosis ___ Thyroid Hyper
___ Cancer ___ Heart Condition ___ Pacemaker ___ TMJ
___ Carpal Tunnel ___ Hepatitis ___ Parkinson’s ___ Tuberculosis
___ Contagious disease ___ Hernia ___ Pinch Nerve ___ Ulcers
___ Diabetes ___ Herniated Disk ___ Psoriasis ___ Varicose Veins
___ Dizziness ___ Herpes/Shingles ___ Recent Fever ___ Whiplash
___ Eating Disorders ___ Hip Replacement ___ Recent Surgery ___ Other
___ Eczema ___ HIV virus ___ Scoliosis ___

Is this your first massage? ___ Yes ___ No If no, when was your last session? __________________

Desired pressure: ___ Light ___ Firm ___ Deep ___ Unknown

Are you pregnant? ___ Yes ___ No If yes, how many weeks? ____________

Are you wearing any of the following? ___ Contact Lenses ___ Dentures ___ Hearing Aid(s)

Do you have any difficulty lying on your front, back or side? ___ Yes ___ No

Please list any surgeries and injuries (bone breaks/fractures, dislocations, sprains, head/neck/spine injuries, whiplash, vehicle accidents, falls, or other trauma) with approximate dates. ______________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please list any and all drugs and general supplements: __________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Are you currently seeing a healthcare practitioner (chiropractor, physician, psychotherapist, alternative practitioner)?
___ Yes ___ No If yes, please explain: _____________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
CLIENT CONDITION
What are your symptoms that brought you in for massage?
____________________________________________________________________________________________

Type of pain?  ___ Sharp  ___ Dull  ___ Throbbing  ___ Numbness  ___ Aching  ___ Shooting  ___ Burning
___ Tingling  ___ Cramps  ___ Stiffness  ___ Swelling  ___ Other

When did your symptoms appear?
____________________________________________________________________________________________

What treatment(s) have you already received for your condition?

___ Medication  ___ Surgery  ___ Physical Therapy  ___ Massage Therapy  ___ Chiropractic  ___ None  ___ Other
____________________________________________________________________________________________

Circle areas of pain.
Indicate severity using the scale 1 through 5.

1 – Uncomfortable
2 – Moderate
3 – Severe
4 – Intolerable
5 – Debilitating

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Signature: ___________________________________________ Date: ___________________________

Therapist: ___________________________________________ Date: ___________________________