MASSAGE THERAPY BY BRIDGET BROCK LMT

CLIENT INTAKE FORM

Name *

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Date *

MM/DD/YYYY

Date

Occupation *

Gender *

Birthday *

Address *

City *

State *

Zip *

Jotform

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Phone *

(000) 000-0000

Email

example@example.com

Emergency contact *

Phone # *

(000) 000-0000

MEDICAL HISTORY

Do you have or have you had any of the following conditions?

If yes, please type "Yes" in the provided field:

Easy Bruising

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Arthritis / Joint Disorder

Artificial Joint

Pregnant

Atherosclerosis

Epilepsy

Recent Fracture

Blood Disorder

Back/Neck Problems

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Fibromyalgia

Headaches/Migraines

Skin Disease/Lesions

High/Low Blood Pressure

Sprains/Strains

Swollen Glands

Keloid Scarring

Open Sores or Wounds

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Osteoporosis

Carpal Tunnel Syndrome

Circulatory Disorder

Contagious Skin Condition

Allergies

Any other illness or condition

Any recent surgery, including plastic surgery? Please list surgery and approximate date.

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CLIENT INTAKE FORM

Have you had a professional massage before? *

Do you have any difficulty lying on your front, back, or side? *

Please indicate any areas you would like your therapist to focus on during your massage session. *

By signing below, you agree to the following: I 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 and/or strokes may be adjusted to my level of comfort. 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 part should I fail to do SO.

Client Name printed *

Client Name signature *

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Sign Here

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CONSENT FORM

Client Legal Name *

Massage therapy is a profession in which the practitioner applies manual techniques, and may apply adjunctive therapies, with the intention of positively affecting the health and well-being of the client. Massage Therapists do not diagnose or prescribe for medical conditions nor are they allowed to provide treatment for a specific condition without a doctor's supervision. The massage therapist is required to refer you for diagnosis and to follow recommendations of your physician. The massage therapist are happy to adjust pressure, temperature, music volume, work longer on an area or avoid an area.

It is the responsibility of the client to keep the massage therapist informed of any medical treatment currently being taken, and to provide written permission from the physician, chiropractor, physical therapist, etc., that the massage may be continued. The client must also keep the massage therapist informed of any changes in health conditions.

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

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my level of comfort. I further understand that Massage Therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware.

Massage should not be performed under certain medical conditions and I affirm that I have stated all my known medical conditions, and answered all questions honestly.

Client Initials *

MASSAGE THERAPY

CONSENT FORM

I will keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist should I fail to do SO.

This is a Therapeutic Massage session and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment. I understand the Cupping Therapy can leave marks. These marks are not bruises or damage to tissue. These marks can take a few days to fade and no longer be visible.

I understand the Massage Therapist practitioner reserves the right to refuse services to me for any reason that she deems necessary.

My signature acknowledges that I have read and agree to receive the massage therapy and that I will adhere to all of the aforementioned statements that I have initialed.

Client Name printed *

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Client Name signature *

Sign Here

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Late Policy

If the client arrives late, the massage duration will be reduced by this late time and the full amount of service will be charged.

Client Initials *

Date *

MM/DD/YYYY

Date

Print Form Save Continue

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