



BEST FERTILITY MASSAGE

CLIENT INTAKE FORM

CLIENT NAME:

HERBS BY LEAH

MASSAGE CLIENT INTAKE FORM

CLIENT INFORMATION

Name: _____ Date: _____
Occupation: _____ Age: _____ ☐ Female ☐ Male ☐ NB
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Email: _____
Emergency contact: _____ Phone #: _____

Are you under the age of 17? If yes, you must have the written consent of your parent or guardian to receive massage therapy services.

MEDICAL HISTORY

Do you have or have you had any of the following conditions? If yes, please select all that apply:

- | | | |
|-----------------------------------------------------|-------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Arthritis / joint disorder | <input type="checkbox"/> Endometriosis or Adenomyosis | <input type="checkbox"/> Ovarian issues |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eczema | <input type="checkbox"/> Retroverted (tilted) uterus |
| <input type="checkbox"/> Blocked tubes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Recent accident/injury |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Recent fracture |
| <input type="checkbox"/> Back/neck problems | <input type="checkbox"/> Fibroids, Polyps or Cyst | <input type="checkbox"/> Spinal Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Carpal tunnel syndrome | <input type="checkbox"/> Heart conditions | <input type="checkbox"/> Skin disease/lesions |
| <input type="checkbox"/> Circulatory disorder | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Sprains/strains |
| <input type="checkbox"/> Contagious skin condition | <input type="checkbox"/> Hydrosalpinx | <input type="checkbox"/> Smoke |
| <input type="checkbox"/> Prolapsed uterus | <input type="checkbox"/> Injuries | <input type="checkbox"/> Tennis elbow |
| <input type="checkbox"/> Prolapsed bladder | <input type="checkbox"/> Open sores or wounds | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Varicose veins |

☐ Currently Pregnant? Due Date: _____

Please explain any checked above: _____

Current Medications: _____

Any medical conditions your therapist should be made aware of? : _____

Any recent surgery, including plastic surgery? ☐ No ☐ Yes: _____

Areas of pain/tension _____

Areas to be avoided _____

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MASSAGE INFORMATION

Have you had a professional massage before? ☐ No ☐ Yes

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

Do you have any allergies to oils, lotions, or ointments? ☐ No ☐ Yes

Do you have sensitive skin? ☐ No ☐ Yes

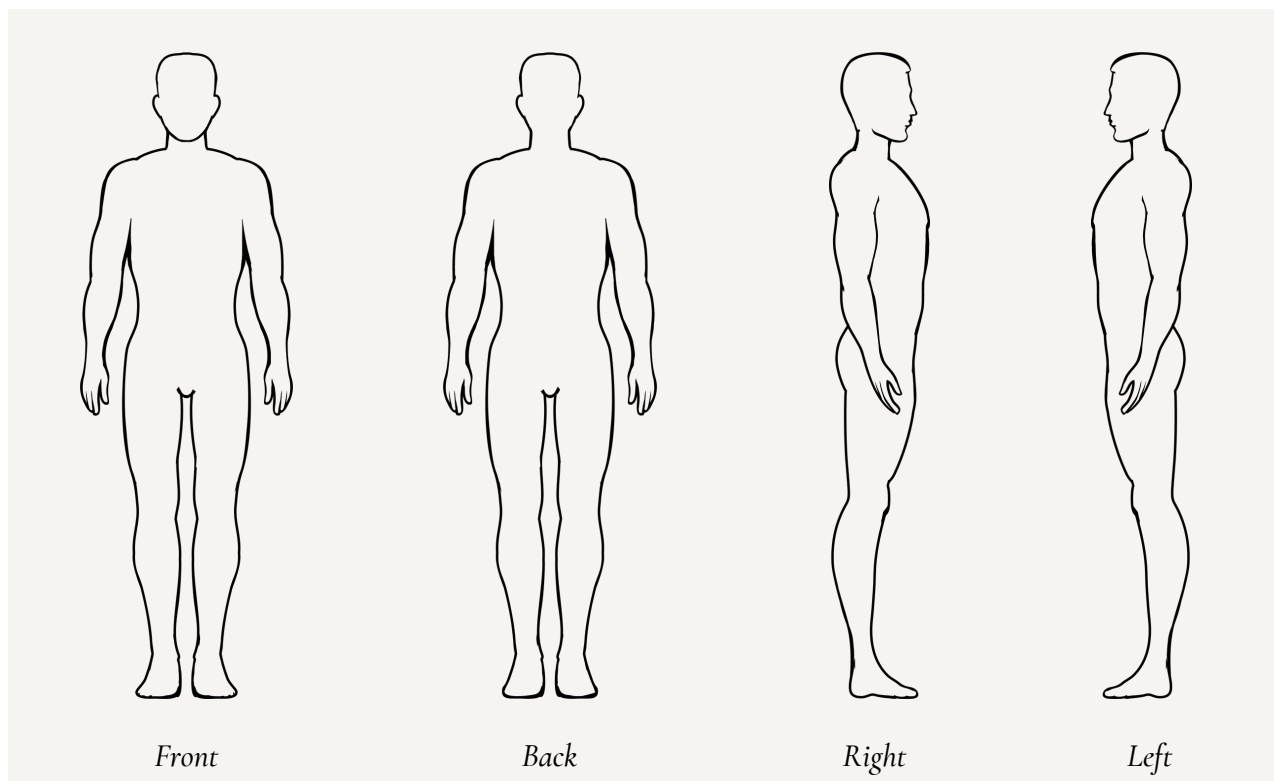
Are there any areas (feet, face, abdomen) you do not want massaged? _____

What type of massage are you seeking? ☐ Manual Lymphatic Drainage

☐ Relaxation ☐ Our Sobada Maya /Abdominal massage ☐ Pregnancy

What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep

Mark any specific areas you would like your therapist to concentrate on:



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)

Date

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Client Legal Name: _____

Massage therapy is not a substitute for medical examination or diagnosis. It is recommended that I see a physician for any physical ailment that I may have. I understand that the massage therapist does not prescribe medical treatments or pharmaceuticals and does not perform any spinal adjustments. I am aware that if I have any serious medical diagnosis, I must provide a physician's written consent prior to services.

The licensee shall drape the breasts of all female clients and not engage in breast massage of female clients unless the client gives written consent before each session involving breast massage.

Draping of the genital area and gluteal cleavage will be used at all times during the session for all clients.

The licensee must immediately end the massage session if a client initiates any verbal or physical contact that is sexual in nature.

If the client is uncomfortable for any reason, the client may ask the licensee to end the massage, and the licensee will end the session. The licensee also has a right to end the session if uncomfortable for any reason.

CONSENT

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

_____ I understand that if I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to 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: _____

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- _____ 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 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)

Client Name (signature)

Date

Therapist (signature)

Date

To be completed by the licensee

Type of massage service/technique to be used: _____

Parts of the body to be massaged (including indications and contraindications): _____

Licensee signature: _____ **Date:** _____

(Name as it appears on Massage Therapist license)