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:

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

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

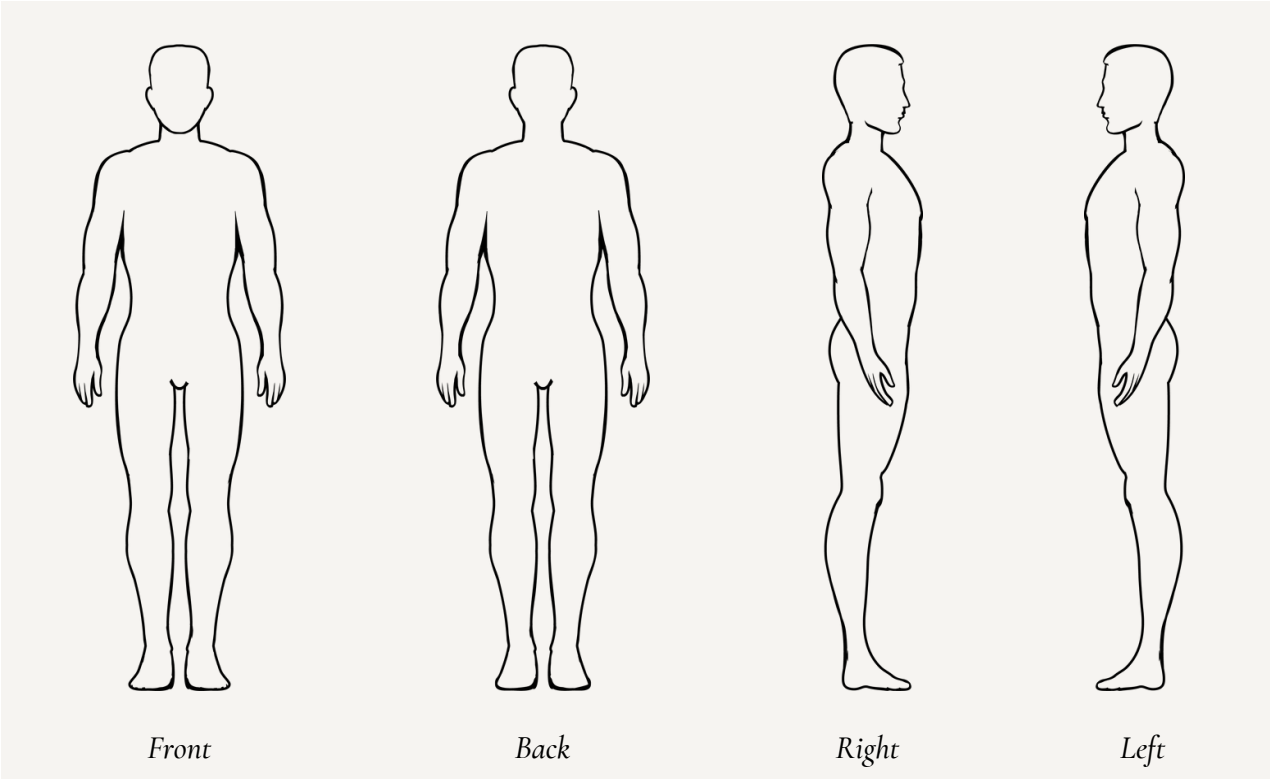
Are there any areas (feet, face, abdomen) you do not want massaged? _____

What type of massage are you seeking?

☐ Relaxation ☐ Our Sobada Maya /Abdominal massage ☐ Pregnancy ☐ Manual Lymphatic Drainage

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

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



Front *Back* *Right* *Left*

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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MASSAGE CLIENT INTAKE FORM

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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MASSAGE CLIENT INTAKE 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 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): _____

_____

_____

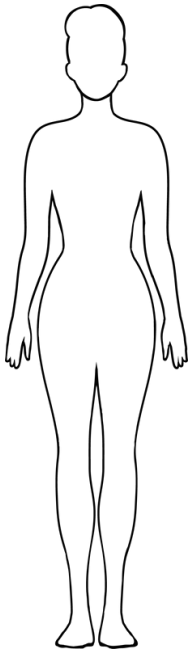
Licensee signature: _____ **Date:** _____

(Name as it appears on Massage Therapist license)

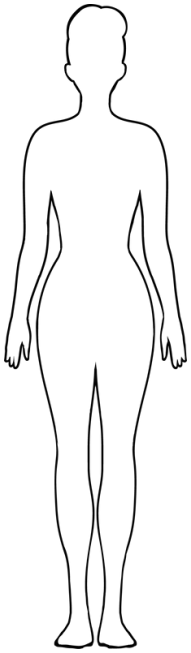
CLIENT INTAKE FORM

Name: _____ Date: _____

Date of birth: _____ Phone: _____ Email: _____



Front



Back

Right

Left

Subjective symptoms:
(Client complaints - Onset/Location/Intensity/Frequency/Aggravating Factors)

_____

_____

_____

_____

Objective findings:
(Visual assessment/Palpable/Test results)

_____

_____

_____

_____

Assessments goals:
Identify the client's condition and analyze their progress.

_____

_____

_____

_____

Plan:
(Future treatment / Frequency / Self-care)

_____

_____

_____

_____

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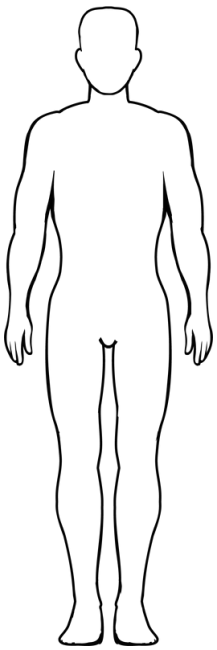

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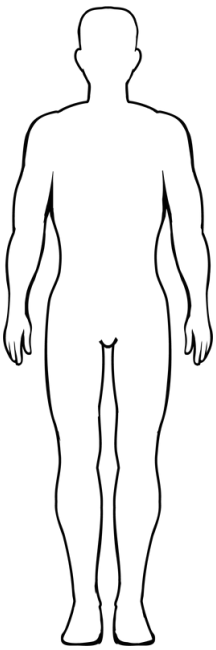

Back

Right

Left

Subjective symptoms:
(Client complaints - Onset/Location/Intensity/Frequency/Aggravating Factors)

_____

_____

_____

_____

Objective findings:
(Visual assessment/Palpable/Test results)

_____

_____

_____

_____

Assessments goals:
Identify the client's condition and analyze their progress.

_____

_____

_____

_____

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(Future treatment / Frequency / Self-care)

_____

_____

_____

_____

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CANCELLATION POLICY

Our goal is to provide quality care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy.

Appointments are in high demand, and your early cancellation will give another person the opportunity to have access to timely care. This policy enables us to better utilize available appointments for our clients.

At the time of booking your appointment you will be asked to pay a _____ deposit that will be credited towards your treatment/s.

Time has been specifically reserved for your appointment, procedure, or treatment. If you need to cancel or reschedule your appointment you must call at least 24 hours prior to your appointment and your deposit will either be refunded or pushed for a future appointment. However, providing less than 24 hours' notice will require you to pay a _____ cancellation fee.

If you arrive more than 15 minutes late for your appointment it is considered a no-show and you will be charged the cancellation fee.

We are happy to answer any questions regarding this cancellation policy.

I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by it's terms. I agree to pay the cancellation fee in the event of a missed appointment.

_____ _____

Client Name (printed) : *Date*

_____ _____

Client Name (signature) : *Date*

We're excited to have you on board! After your payment, please click the button and fill out the intake form. Don't forget to email it to us at Admin@bestfertilityMassage.com as soon as posible - it's a Texas State requeriment. Thank you for helping us get started on this jouney together!