WEST AUSTIN MASSAGE

relaxation at your doorstep

Client Intake Form & Agreement

Personal Information

Name_____ Date of Birth _____

Address _____

Phone_____ Email _____

Occupation _____

Emergency Contact Name _____ _____ Emergency Phone _____

Medical History

Are you taking any medications or supplements? ☐ no ☐ yes, please list:_____

Are you currently pregnant? ☐ no ☐ yes: how far along? _____ Any high risk factors? _____

Do you suffer from chronic pain? ☐ no ☐ yes:_____

What makes it better? _____

What makes it worse? _____

Have you had any orthopedic injuries/surgeries? ☐ no ☐ yes: _____

Please check all of the following that apply to you in your medical history OR present time:

☐ Cancer ☐Headaches/Migraines ☐Arthritis ☐Diabetes ☐Skin Allergies ☐ Allergies:_____

☐Joint Replacement(s) ☐ High/Low Blood Pressure ☐Neuropathy ☐ Fibromyalgia ☐ I.B.S.

☐ Stroke ☐ Heart Attack ☐ Lyme Disease ☐ Blood Clots ☐ Numbness ☐ Sprains or Strains

Explain any conditions you have marked above: _____

Any other conditions or problems not listed:_____

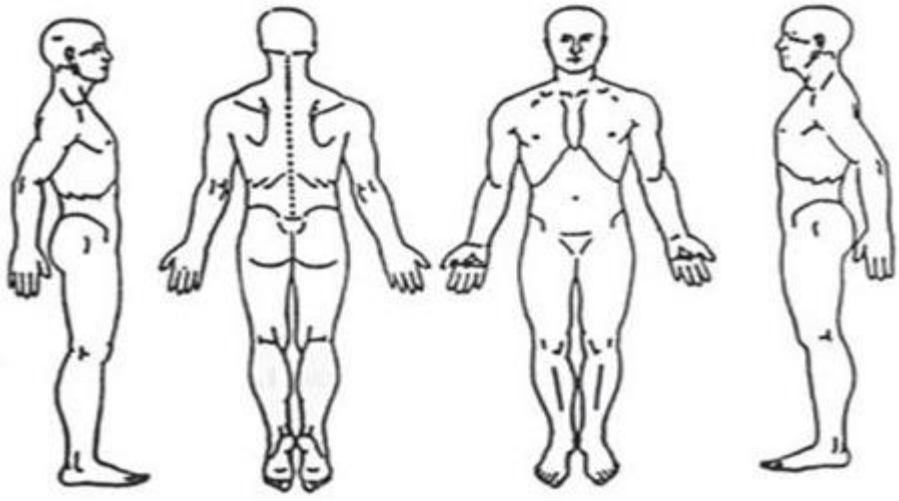
Have you had a professional massage before? ☐ no ☐ yes, last time was: _____

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

Are there any areas (feet, face, etc.) you *do **NOT*** want massaged? ☐ no ☐ yes: _____

What are your goals for this treatment session? _____

Please circle any areas of discomfort:



Is there anything else you would like me to know about you?

_____

_____

West Austin Massage and Client Agreement

Massage therapy is not a substitute for professional medical care or counseling. I do not diagnose or prescribe medications of any kind. I may refer you to another healthcare provider if you are experiencing a condition that is contradictory to massage therapy. There is no breast massage or sexual massage of any kind with West Austin Massage.

All information that is shared during the massage session is held strictly confidential.

By signing below I do hereby acknowledge that the above information that I provided is complete and accurate. I stated all my known medical conditions and medications and I will **inform the message therapist of any changes in my health status**. I understand that the information that I provided is strictly confidential. I also understand that the scope of massage therapy practice and the policies listed above.

Client signature_____ **Date**_____

Therapist signature _____ **Date**_____