LMT / Date

Appt. Time / Length

MASSAGE THERAPY CLIENT INTAKE FORM
CONFIDENTIAL HEALTH ASSESSMENT CONSULTATION FORM

NAME:	BIRTH DATE:	DUE DATE: (PREGNANT)
ADDRESS:	CITY:	ZIP:
EMAIL: *(Please indicate under Special Promotions if you would like to be notified)*	CELL PHONE#	PHONE CARRIER:
EMERGENCY CONTACT/PHONE#:	OCCUPATION:	REFERRED BY:

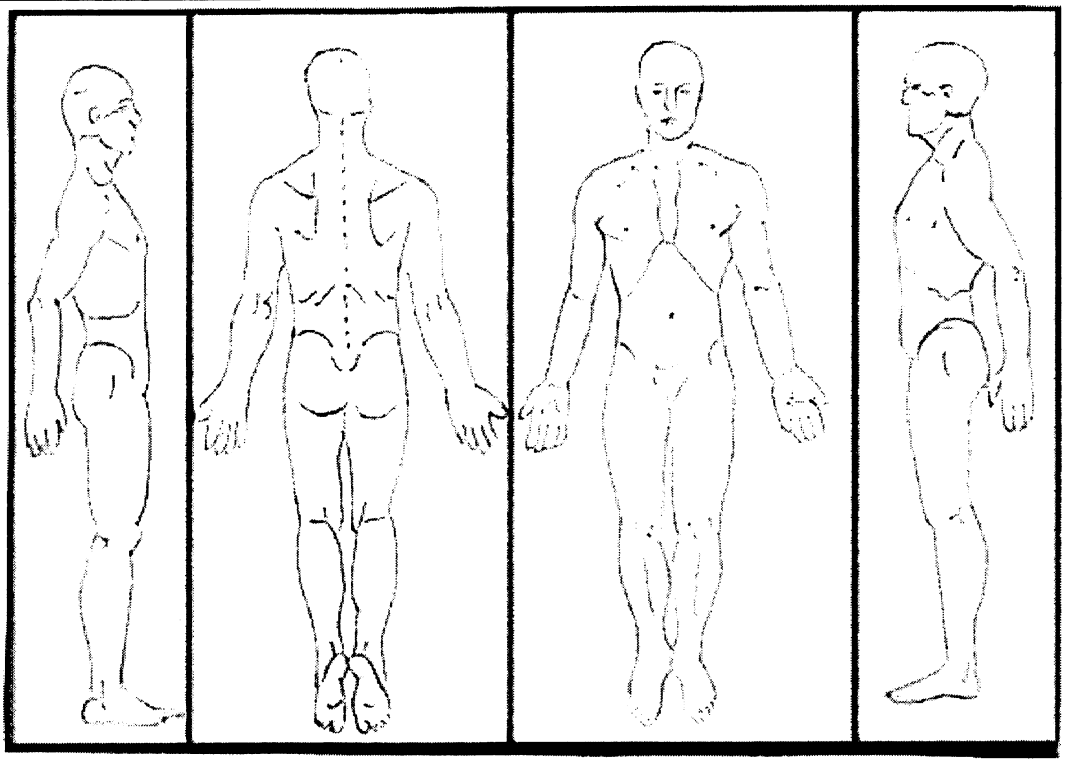
PLEASE CHECK ALL THAT APPLY:		PLEASE CHECK ALL THAT APPLY:		FOR PREGNANT WOMEN(CONT.)	
HEART TROUBLE		HIGH OR LOW BLOOD PRESSURE		COMPLICATIONS OR RISKS?	
RESPIRATORY PROBLEMS/DISORDERS		VARICOSE VEINS		SENSITIVE TO ODORS	
DIABETES		BRUISES, CUTS OR OPEN WOUNDS		REFERRAL FROM PHYSICIAN	
ARTHRITIS/BURSITIS/REHEUMATISM		SWOLLEN TISSUE / INFLAMMATION		MIDWIFE:	
BLOOD CLOT DISORDERS		OSTEOPOROSIS / BONE DISORDERS		PHONE:	
CANCER		OTHER:		IS PREGNANCY GOING WELL	
FEVER				TWINS:	
ANY CONTAGIOUS ILLNESS				PREVIOUS MISCARRIAGE:	
RASH, SKIN IRRITATIONS/DISORDERS		**FOR PREGNANT WOMEN**		TOXEMIA/PRE-ECLAMPSIA	
MIGRAINES OR HEADACHES		COMPLICATIONS OR RISKS?		MORNING SICKNESS	
DIZZINESS OR FAINTING SPELLS		DELIVERY DATE:		FETUS MOVEMENT IN 24 HRS.	
NEUROLOGICAL DISORDERS		OB DR.:		OTHER:	
SPINAL DEVIATIONS		PHONE:			

WHAT ARE YOUR GOALS FOR THIS SESSION?	
SURGERIES AND OR ACCIDENTS - LIST DATES	
MEDICATIONS ON CURRENTLY	
PURPOSE OF MEDICATIONS	
ALLERGIES ESPECIALLY FOOD ALLERGIES	
SKIN CONDITIONS	
COMMENTS:	
OTHER:	

PLEASE COMPLETE OTHER SIDE

THE TEXAS ADMINISTRATIVE CODE, TITLE 25, PART 1, CHAPTER 140, SUBCHAPTER H, RULE 140.304 STATES THAT THIS INITIAL CONSULTATION DOCUMENT IS REQUIRED AND THAT IT MUST INCLUDE THE FOLLOWING INFORMATION:

THE TYPE OF MASSAGE TECHNIQUES TO BE USED:	SWEDISH, DEEP TISSUE, TRIGGER POINT, SPORTS, AND/OR ESALEN STYLE MASSAGE, FOR RELAXATION AND RELIEF OF MUSCLE PAIN, AND/OR LYMPHATIC DRAINAGE THERAPY FOR MINOR EDEMA, SWELLING, AND WATER RETENTION.
THE MASSAGE THERAPIST WILL NOT PERFORM BREAST MASSAGE ON FEMALE CLIENTS WITHOUT THE WRITTEN CONSENT OF THE CLIENT.	FOR LYMPHATIC DRAINAGE OF SORE OR SWOLLEN BREAST TISSUE. IF APPLICABLE, PLEASE DISCUSS WITH ME AND SIGN HERE: I CONSENT: **X**
DRAPING WILL BE USED DURING THE SESSION, UNLESS OTHERWISE AGREED TO BY BOTH CLIENT AND THERAPIST.	"DRAPING" MEANS THAT YOUR BODY WILL BE MODESTLY COVERED BY A SHEET DURING THE MASSAGE. IF YOU DO NOT WISH TO BE COVERED BY A SHEET, PLEASE DISCUSS WITH THERAPIST AND SIGN HERE: **X**
IF THE CLIENT IS UNCOMFORTABLE FOR ANY REASON, THE CLIENT MAY ASK THE THERAPIST TO CEASE THE MASSAGE, AND THE THERAPIST WILL DO SO.	AS A THERAPIST, I ALSO RESERVE THE RIGHT TO TERMINATE THE SESSION IN THE EVENT OF ANY SORT OF ABUSIVE BEHAVIOR FROM THE CLIENT. IF CLIENT MISBEHAVIOR SHOULD RESULT IN AN ABBREVIATED SESSION, CLIENT WILL BE EXPECTED TO RENDER FULL PAYMENT.
THE PARTS OF THE CLIENTS BODY THAT WILL BE MASSAGED OR THE AREAS OF THE CLIENTS BODY THAT WILL BE AVOIDED DURING THE SESSION, INCLUDING INDICATIONS AND CONTRAINDICATIONS	ON THE CHART BELOW, PLEASE: **X** PLACE AN "X" ON ANY SPOTS TO BE AVOIDED **O** CIRCLE ANY SPOTS THAT NEED EXTRA ATTENTION **T** PLACE A "T" ON SPOTS THAT ARE TICKLISH.



PLEASE NOTE: SAME DAY APPOINTMENTS SHOULD BE BOOKED BEFORE 3:00 P.M. WE REQUEST THAT YOU HONOR OUR 24-HOUR CANCELLATION AND RESCHEDULING POLICY. IF YOU CANNOT MAKE YOUR SCHEDULED APPOINTMENT, YOU WILL BE CHARGED FULL FEES.

I AM AWARE THAT THE MASSAGE THERAPIST IS AN INDEPENDENT CONTRACTOR AND NOT AN EMPLOYEE OF THE @PEACE SPADOES NOT DIAGNOSE ILLNESS OR DISEASE, DOES NOT PRESCRIBE MEDICATIONS, AND THAT SPINAL MANIPULATIONS ARE NOT PART OF MASSAGE THERAPY. I UNDERSTAND THAT MASSAGE THERAPY IS NOT A SUBSTITUTE FOR MEDICAL TREATMENT OR MEDICATIONS. IT IS RECOMMENDED THAT I CONCURRENTLY WORK WITH MY PRIMARY CAREGIVER FOR ANY CONDITIONS THAT I MAY HAVE. I HAVE READ AND AGREE TO THE ABOVE.

Client Signature:		Date:
LMT Signature:		Date:

PLEASE COMPLETE OTHER SIDE