MASSAGE & MEDITATION

OLGA VICTORIYA

CLIENT INTAKE

Full Name _____

Birth Date_____ Gender (circle) F / M

Occupation_____

Telephone_____E-mail_____

Referred By_____

Emergency Contact / Guadian_____

What is your primary complaint(s) today :_____

Do you have any of the these conditions now? (circle) Blood Pressure, Fever, Pain, Skin Infection, Cuts, Bruises, Wounds, Inflammation.

Medical History (include dates)

Surgeries_____

Traumas_____

Illnesses (circle): Allergies / Easy Bruising / Skin Disorders / Herniated discs / Varicose Veins / Phlebitis / Seizures / Heart Disease / Pacemaker / Clot / Thrombosis / Aneurysm / Arthritis / Stroke / High Blood Pressure / Low Blood Pressure / Kidney Disease / Diabetes / Migraines / Fibromyalgia / Osteoporosis / Epilepsy / Cancer / Other

For Women Only Are you pregnant or trying to become? Yes / No If Yes, then how many weeks?

_____

Have you ever received massage therapy? (circle) Yes / No

What type of touch do you prefer? (circle)

light-meditative medium-relaxing deep-trigger point

Is any areas on your body you want me to focus more?_____

Is any areas on your body you do not want to be touched? Head / Face / Abdomen / Back / Arms / Hands / Legs / Feet

From 0-10 what is the level of:

Stress _____Energy_____Pain_____

WHAT FREE ADD-ONS WOULD YOU LIKE TO INCLUDE TO YOUR SESSION:

Sage Smudging, Hot Towels, Far Infrared, Photon Light, Negative ions, Transcranial Magnetic Stimulation, Musical Affirmations

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INFORMED CONCENT

– I understand that the treatment I receive is intended to enhance general health and relaxation, decrease pain and tension, increase energy level, range of motion and circulation.
– If I experience pain or discomfort at any time during the session I will inform the therapist promptly
– I understand that treatments are not a substitute for medical treatment or medications, and that it is recommended that I work with my primary care physician for any medical condition I may have.
– Because some of the treatments should not be performed under certain circumstances, I have informed the therapist of all my known physical and medical conditions as well as medications.
– I will keep the therapist updated on any changes.
– I understand that there shall be no liability on the therapist's part due to my forgetting to relay any pertinent information.
– I understand that any illicit or sexual remarks or advances during the session will result in immediate termination of the session.
– I also understand that the therapist reserves the right to refuse service to anyone when they deem it necessary.

Client signature: _____

Date:_____