Health Through Hands - Samantha Mitchell, LMT

Confidential Client Intake Form

PERSONAL INFORMATION			
Name			DOB
Address	City	State	Zip
Primary Phone	Secondary Phone		
Email			
Have you received massage therapy before?	If so, how often?		

THE FOLLOWING INFORMATION WILL ASSIST IN GIVING YOU A SAFE AND EFFECTIVE MASSAGE PLEASE ANSWER TO THE BEST OF YOUR KNOWLEDGE	
Primary Care Physician	
List all conditions currently monitored by a Health Care Provider (Primary Care Physician, Chiropractor, Physical Therapist, ect):	
Please list any current medication(s) you are taking:	
Do you have allergies to oils, lotions, nuts or scents?	
What are your reasons for seeking massage? □ Relaxation/ Stress relief □Pain management □ Injury recovery/ prevention	
Occupation	Do you sit, stand, or drive for long periods of time?
Do you exercise or participate in sports regularly? How often? Describe sport or exercise.	

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU NOW OR IN THE PAST

- □ Allergies
- □ Arthritis
- □ Asthma
- □ Fractured Bones
- □ Bruise Easily
- □ Cancer Type_____
- □ Smoker
- □ Numbness/ Tingling
- □ Cold Hands/ Feet
- □ Diabetes
- □ Edema (Swelling)
- □ Fibromyalgia
- □ Headaches/ Migraines
- □ High/ Low Blood Pressure
- □ Contagious Disease-explain_____
- □ Heart Condition-explain_____
- □ Sciatica
- □ Pregnant, trimester_____
- □ Osteoporosis
- □ Varicose Veins
- □ Other_____

Are your wearing? □ Dentures □Contact Lenses □Hearing Aide □Hairpiece □Prosthetics

Please describe any injuries or surgeries you have had _____

INFORMED CONSENT: PLEASE READ THE FOLLOWING STATEMENT PRIOR TO SIGNING THIS FORM

I understand that the massage provided my Samantha Mitchell, LMT is intended to enhance relaxation, reduce pain caused by muscular tension, increase range of motion, improve circulation, and offer a positive experience of touch. It is my choice to receive massage therapy, and I give consent to receive treatment. I understand that Massage Therapists DO NOT diagnose illness, disease or any other physical or mental disorders. Massage is not a substitute for medical examination and/or diagnosis. 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 health and medications and I understand that there shall be no liability on the therapist's part should I neglect to do so. 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 understand that any illicit or sexually suggestive remarks or advances made before or during the scheduled massage session will result in immediate termination of the current therapy session, and I will be liable for payment of the full scheduled appointment. Draping will be used during the session – only the area being worked on will be uncovered. Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 18.

Clients Signature_____Date_____

Therapists Signature_____Date_____