

## Confidential Client Intake Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

### **General Questions:**

How are you feeling today? (emotionally, physically?)

Have you ever received a professional massage before? If so, how long ago?

What end result would you like from your treatment today?

What level of pressure do you prefer?  Light  Medium  Deep

Any areas you would like special attention?

Any areas you would like massage avoided?

Are you allergic or sensitive to any creams or oils?

### **Occupational Questions:**

What is your main activity at work? Phone  Sitting  Computer  Labor  Driving

Are you right or left handed?

What physical activities you participate in regularly?

### **Medical History**

Are you currently under the care of a physician? If so, why?

Please list current medications: Any side effects?

List accidents/injuries: Date of incident?

Have you ever been diagnosed with cancer? If so, what type and when?

Have you ever had a related sports injury? If so what type?



DEEPFEET  
BAR || THERAPY

## Medical History and Information

Check any or all that apply to your present health:

- |                                                  |                                                 |                                                    |
|--------------------------------------------------|-------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> headaches               | <input type="checkbox"/> chronic pain           | <input type="checkbox"/> varicose veins            |
| <input type="checkbox"/> inflammation            | <input type="checkbox"/> muscle or joint pain   | <input type="checkbox"/> blood clots (DVT)         |
| <input type="checkbox"/> carpal tunnel           | <input type="checkbox"/> numbness/tingling      | <input type="checkbox"/> high/low blood pressure   |
| <input type="checkbox"/> jaw pain/teeth grinding | <input type="checkbox"/> sprains/strains        | <input type="checkbox"/> diabetes/hypoglycemic     |
| <input type="checkbox"/> athletes foot           | <input type="checkbox"/> stent/shunt /pacemaker | <input type="checkbox"/> MS, Parkinsons            |
| <input type="checkbox"/> plantar warts           | <input type="checkbox"/> spinal abnormalities   | <input type="checkbox"/> cancer/tumors             |
| <input type="checkbox"/> depression/anxiety      | <input type="checkbox"/> arthritis              | <input type="checkbox"/> infectious disease        |
| <input type="checkbox"/> PTSD                    | <input type="checkbox"/> tendonitis             | <input type="checkbox"/> contagious skin disorders |
| <input type="checkbox"/> fibromyalgia            | <input type="checkbox"/> herniated disk         | <input type="checkbox"/> open wounds, rashes       |

Other: \_\_\_\_\_

**Women only:** \_\_\_\_\_Pregnant /What trimester?\_\_\_\_\_ Breast Feeding?\_\_\_\_\_

\_\_\_\_\_Breast Implants/ When?\_\_\_\_\_ Reconstructive/ Aesthetic?\_\_\_\_\_

### To comply with informed consent I will discuss the following with you prior to your treatment:

1. What to expect from your Ashiatsu treatment
2. Proposed treatment plan and goals
3. Explanation of analog pressure scale I will be using during your treatment
4. Any contraindications or precautions for receiving Ashiatsu massage

### *Please take a moment to carefully read the following information and sign where indicated*

I understand that the massage/bodywork I receive is provided for basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session I will immediately inform the practitioner so that the pressure and or/ strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for an examination, diagnosis or treatment of disease/injuries. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there should be no liability on the practitioner's part should I forget to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in termination of the session, and I will be responsible for payment of the scheduled session. I agree and adhere to the cancellation policy set forth and will be responsible for charges if I fail to show for my scheduled appointment.

Signature \_\_\_\_\_ Print: \_\_\_\_\_ Date \_\_\_\_\_