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:

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