



Client Intake Form and Liability Waiver – Page 1

Name _____ Phone (____) _____ DOB _____

Address _____ City _____ State _____ Zip _____

Email _____ Yes, Please include me on your mailing list

Referred by _____ Phone (____) _____

In case of emergency _____ Phone (____) _____

Occupation _____ Sex Male Female

Physician _____ Phone (____) _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever received a professional massage before? Yes No How Recently? _____

What are your goals for today's session? _____

What kind of pressure do you prefer? Light Medium Deep Other _____

Do you currently have or have you ever experienced any of the following symptoms? Please Explain.

- Checkboxes for symptoms: Allergies, Back Pain, Cancer, Eczema, High Blood Pressure, Kidney Disease, Seizures/Epilepsy, Arthritis, Bruise Easily, Contagious Disease, Freq. Headaches, Instrumentation, Lung Disease, Thyroid Disorder, Asthma, Diabetes, Heart Disease, Joint Swelling, Osteoporosis, Varicose Veins.

I am committed to helping you achieve optimum health. Would you like a referral to any of the following?

___ Chiropractor ___ Homeopath ___ CranioSacral Therapist
___ Physical Therapist ___ Midwife/Doula

Please describe any Stress you are currently under? _____

Please describe any Injuries or Broken Bones in the last 2 years? _____

Have you had any Major Surgeries and when? _____

If you are currently taking any Medications, please describe. _____

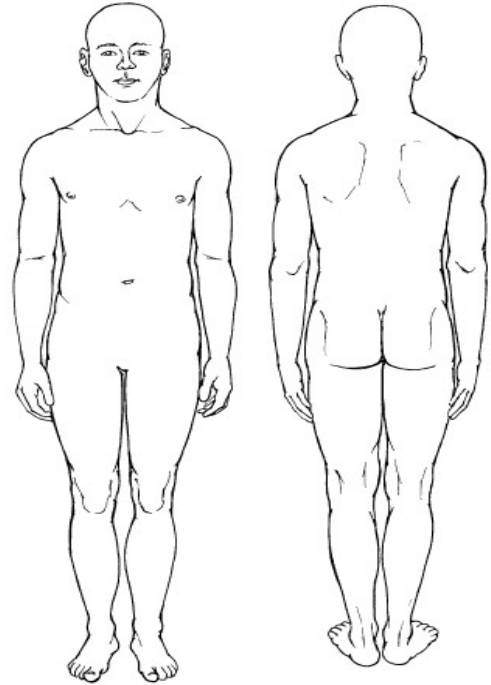
Females: Are you Pregnant? Yes No If yes, which Trimester? First Second Third



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On the figure to the right, please mark any areas of:

- T** = Tension
- S** = Soreness
- N** = Numbness
- P** = Pain



Please feel free to explain your symptoms, as necessary:

Liability Waiver

I understand that the massage/bodywork I receive is provided for the 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 or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/ bodywork should not be performed under certain medical conditions, 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 shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____

Consent to Treatment of a Minor

By my signature below, I hereby authorize _____ to receive
 therapeutic massage and body work treatments from a qualified therapist of
 Healing Hands Therapeutic Massage, as they deem necessary.

Parent or Guardian Signature _____ Date _____