NICCI SCHOCK LMT, NCTMB, HHC

Client Intake

CONFIDENTIAL INFORMATION

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Name_____Date of birth_____

Email_____

Address_____

State_____City_____Phone _____

Occupation _____

Have you ever received massage therapy? _____Yes_____No

Are you currently taking any medications? _____Yes _____No

If yes, please list names of medications and diagnosed conditions_____

_____

_____

Have you had any of the following conditions?

___arthritis
___diabetes
___blood clots
___broken/dislocated bones
___bruise easily
___cancer
___chronic pain
___constipation/diarrhea
___auto-immune condition
(AIDS, fibromyalgia, lupus)
___hepatitis (A, B, C, other)
___skin conditions
___stroke
___surgery
___TMJ disorder

___depression, panic disorder, other psych condition
___diverticulitis
___headaches
___heart conditions
___back problems
___high blood pressure
___insomnia
___muscle strain/ligament sprain
___pregnancy
___scoliosis
___seizures
___whiplash
____lymphedema
___chemical dependency (alcohol, drugs)

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Do you have any of the following today?

_____skin rash _____cold/flu ____open cuts _____severe pain

_____fever in last 24 hrs _____injuries/bruises

Do you have any allergies?

_____medications _____foods (nuts, etc.)

_____environmental allergens (dust, pollen, fragrances)

_____reactions to skin care products

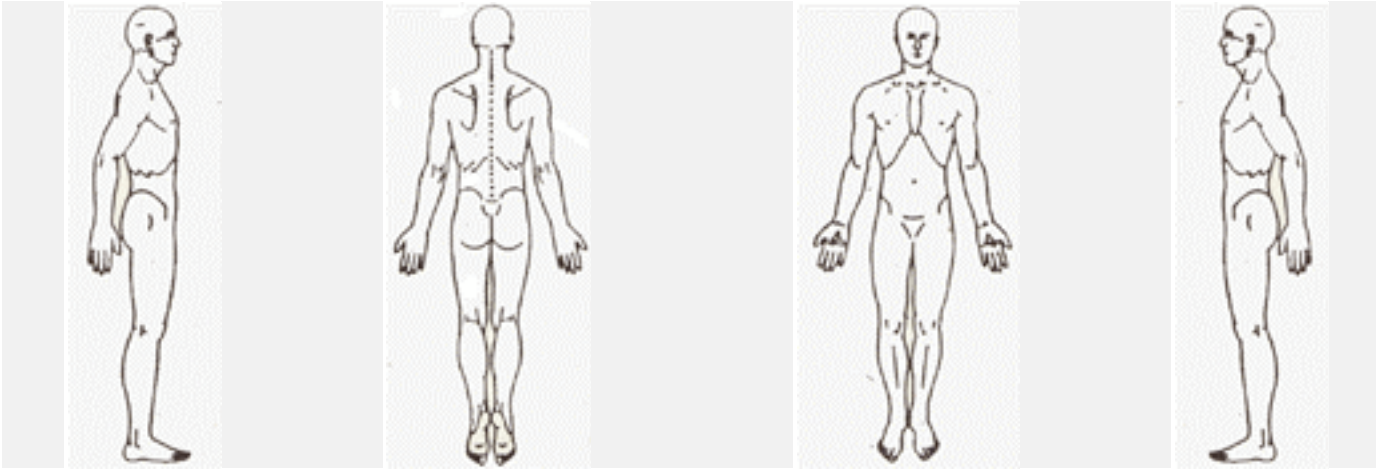
If any of the above are checked, please provide details: _____

_____

Are you wearing any? _____contact lenses _____hearing aid _____hairpiece

Do you have any of the following implants? _____ pace maker _____ breast

Please indicate with an (X), any areas in which you are feeling discomfort/tension:



What are your goals for this session?_____

_____

_____

The following sometimes occur during massage and are normal responses to relaxation: change in breathing pattern, stomach gurgling, emotional feelings, movement of intestinal gas, energy shifts, and sleepiness. Trust your body to express what it needs and feel free to move or change position accordingly.

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Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.

2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.

3. Because massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

4. I do forever release the practitioner and their insurers, from all liability of any nature whatsoever, whether past, present, or future for injury or damage which may occur as a result of my receiving Massage Therapy. I agree to hold harmless and defend the practitioner of and all actions, claims, or other legal or administrative action that has arisen or may arise from my participation in this therapy.

5. I agree to the following lateness policy. If late for a session, I understand that the time remaining will be modified to a partial treatment. As a courtesy to the therapist and other clients, the session will not be extended.

6. I agree to the following cancellation policy. I understand that if I need to cancel my appointment, I will do so 24 hours prior to the appointment time or be liable for the cost of the session.

Signature:_____Date_____