



828.432.2008

# CLIENT INTAKE AND CONSENT FORM

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

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

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

How did you hear about **LaFrance Massage Therapy**? \_\_\_\_\_

Occupation: \_\_\_\_\_

If you have conditions requiring consultation with your doctor, please include their name and number:

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Permission to contact: \_\_\_\_\_

*Initials*

Have you ever received a professional massage?  No  Yes How recently? \_\_\_\_\_

What are your massage goals? \_\_\_\_\_

How much pressure do you normally prefer?  Light  Medium  Firm  Not Sure

Please indicate any areas you do NOT wish to have massaged:

- face       head       neck       chest (not breasts)       abdomen       back
- arms       pelvis (not genitals)       buttocks       thighs       legs       feet

For any of the following to which you answer **Yes**, please explain as fully as possible in the comments.

- |   |   |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a flu or fever?          | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have allergies?   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have diabetes?                | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from seizures?   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have frequent headaches?      | <input type="checkbox"/> Yes <input type="checkbox"/> No Any broken bones in past 2 years?                                      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you having trouble sleeping?     | <input type="checkbox"/> Yes <input type="checkbox"/> No Any surgery/accident in past 2 years?                                  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from frequent stress?  | <input type="checkbox"/> Yes <input type="checkbox"/> No Any surgery/accident in past 24 hours?                                 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from arthritis?        | <input type="checkbox"/> Yes <input type="checkbox"/> No Have cardiac or circulatory condition?                                 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have osteoporosis?            | <input type="checkbox"/> Yes <input type="checkbox"/> No Ever been diagnosed with cancer?                                       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any skin conditions?     | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from back pain?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have varicose veins?          | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have numbness/stabbing pain?                                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any contagious diseases? | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you touch sensitive in any areas?                                  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant?                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high/low blood pressure or take blood pressure medication? |

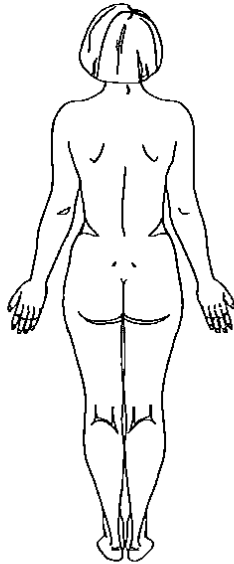
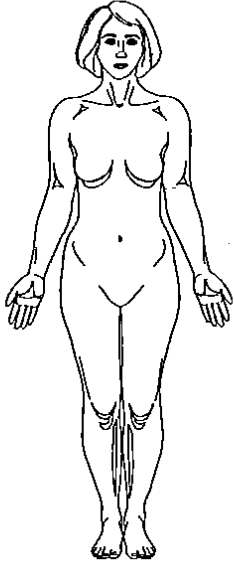
Comments/Other Conditions: \_\_\_\_\_

List any medications you are currently taking and the conditions they address: \_\_\_\_\_

List activities/exercise/hobbies you regularly participate in, including frequency: \_\_\_\_\_

Any additional information you feel the therapist should know: \_\_\_\_\_

Please indicate areas of tension, pain or stress you are currently experiencing on the figures below.



Mark your discomfort level on this scale:



Describe discomfort:

- Mild  Moderate  Disabling
- Constant  Occasional  Rare
- Chronic/Recurring  Recent/New
- Worsening  No Change  Improving

What has your treatment been?

\_\_\_\_\_

**HISTORY of disorders:** (Helps determine treatment options) Please circle any conditions below that you have been or are currently being treated for. List the name of the physician(s) treating this disorder:

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Please review the list below and check those conditions that have affected your health either recently or in the past.

**Musculoskeletal**

- Arthritis
- Bursitis
- Chronic Fatigue
- Chronic Pain in:
  - Neck
  - Hip
  - Low Back
  - Mid Back
  - Upper Back
  - Arm
  - Leg
  - Shoulder
  - Wrist/Hand
- # of Hrs. on computer daily: \_\_\_\_\_
- Cysts/Lipoma
- Fibromyalgia
- Gout (in: \_\_\_\_\_)
- Muscle Strain/Sprain
- Osteoporosis
- Planter Fasciitis
- Tendonitis
- TMJ
- Whiplash
  
- Respiratory**
- Asthma
- Bronchitis
- COPD
- Emphysema
- Sinusitis
- Other: \_\_\_\_\_

**Digestive**

- Chronic Indigestion
- Colitis
- Constipation
- Crohn's Disease
- Diarrhea
- Gallstones
- Gas/Bloating
- Gluten Intolerance
- IBS
- Ulcers
  
- Circulatory**
- Anemia
  
- Blood Clots/Phlebitis
- Hemophilia
- Hepatitis
- HIV/AIDS
  
- Hypertension
- Low Blood Pressure
- Mitral Valve
- Palpitations
- Peripheral Artery Disease
- Raynaud's Disease
- Stroke
- Varicose Veins
  
- Skin**
- Athletes Foot
- Easily Irritated Skin
- Eczema/Dermatitis
- Fungal Infections
  
- Impetigo
- Psoriasis
- Other: \_\_\_\_\_

**Nervous System**

- ALS
- Bell's Palsy
- Chronic Headaches
- Dizziness
- Multiple Sclerosis
- Neuritis
- Parkinson's disease
- Seizures/Epilepsy
- Spinal cord injury
- Trigeminal Neuralgia
  
- Other**
- Allergies affecting:
  - Body skin
  - Eyes
  - Facial skin
  - Nose/Sinuses
  
- Stomach/Gut
- Anxiety/Panic Attacks
- BiPolar Syndrome
- Cancer
- Cystitis
- Depression
- Diabetes
- Grieving
- Heart problems
- High Stress
- Hypothyroidism
- Kidney Disease
- Lupus
- Orthopedic pins or plates
- PMS/Menopause difficulties
- Poor Sleep/Insomnia
- Pregnancy
- Other: \_\_\_\_\_

## POLICIES

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

## EXPECTATIONS

A massage therapy session is an experience jointly created by the therapist and the client. Working together, massage encourages stress relief and body awareness. Your therapist will listen and respond to your words and to the tissues in your body to create a safe, healthy and supportive experience. All sessions are client-centered – your comfort and well-being is the highest priority. If you experience any pain or discomfort during the session, you will immediately inform the therapist so that the pressure and/or strokes may be adjusted to your level of comfort. You agree to keep the therapist updated as to any changes in your medical profile and understand that there shall be no liability on the practitioner's part should you fail to do so.

## APPOINTMENTS AND CANCELLATIONS

Please be on time for your appointment. Cancellation is expected 24 hours in advance for both client and therapist. If you provide less than 24 hours notice, and we are unable to fill you appointment time you may be responsible for the fee. If you are late you will receive only the amount remaining of your scheduled appointment.

## ALCOHOL, DRUGS AND OTHER ISSUES

A client's use of alcohol and other drugs diminishes the ability of the therapist to achieve desired results and may be cause to terminate the session. Any behavior that might be interpreted as sexual in nature is cause to terminate the session. Cancellation policy applies.

## REFERRALS

If you have a specific medical condition or specific symptoms, massage may be contraindicated. If you are experiencing a condition that contraindicates massage, you may be referred to another appropriate healthcare provider. Massage should not be construed as a substitute for medical examination, diagnosis or treatment and you should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment you are aware of. The therapist will not diagnose, prescribe drugs or give advice to clients regarding their medical conditions. Referral from your primary care provider may be required prior to service being provided.

## PRIVACY

All client information is held strictly confidential except where required by law.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**Consent to Treatment of Minor:** By my signature below, I hereby authorize The LaFrance Center to administer massage/bodywork to my child or dependant as they deem necessary.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



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