Touch
MASSAGE & INTEGRATIVE HEALING

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Confidential Client Health History, Intake Form & Informed Consent

Client Information:		
Last Name:	First Name:	Middle Initial:
Address:		
Phone:	Email:	
☐ Check here if you **do not** wish to receive updates, specials and new services that I offer via e-mail.		
Date of Birth:	Occupation:	
Emergency Contact & Phone Number:		
Are you currently seeing a healthcare professional? ☐ Yes ☐ No		
If yes, please list names:		
Current Condition(s) treated:		
What is your primary reason for this visit?		
Appointment Reminders: (Please circle which you prefer) Phone / Text / Email		
How did you hear about me??		

Massage and Medical History:
Do you have acute rheumatoid arthritis, malignancy, aneurysm, acute fever? ☐ Yes ☐ No
Are you currently contagious with any condition in the context of touch? ☐ Yes ☐ No
Have you received Massage, Bodywork, or Energy Work in the Past? ☐ Yes ☐ No
If yes, what type and what was your experience?
What is your primary goal and/or complaint for todays session?
What kind of pressure do you like? ☐ Mild ☐ Moderate ☐ Deep
Do you have any allergies or hypersensitivities to massage lotions, oils or aromatherapy? ☐ Yes ☐ No
If yes, please explain:

Massage and Medical History:

Are you currently wearing contact lenses? ☐ Yes ☐ No
Are you currently or did you ever suffer from Seizures? ☐ Yes ☐ No
If yes, are you currently under any Seizure Medication? ☐ Yes ☐ No
Are you currently taking any medications / pain medications? ☐ Yes ☐ No
If yes, what type of medications are you taking?
Are you currently under the influence of Alcohol and/or recreational drugs? ☐ Yes ☐ No
Are you Diabetic? ☐ Yes ☐ No
Do you have any MusculoSkeletal issues? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No. If yes, how many weeks?_____

Please check any Significant Present or Past Health Issues (circle present):

Head	Lower Back	Abdomen	Bladder
Neck	Hips / Pelvis	Liver	Circulatory System
Shoulders	Knees	Kidney	Lymphatic System
Arms	Legs	Gall Bladder	Nervous System
Hands / Fingers	Ankles	Spleen	Reproductive
Upper Back	Heart condition	Large Intestine	Pancreas
Mid Back	Lung	Small Intestine	Other:

Allergies	Smoker	Fatigue	Touch Sensitive
Cancer	High Blood Pressure	Insomnia	Hormone Imbalance
Easily Bruise	Low Blood Pressure	Asthma	Contagious Illness
Hospitalized	Menopause	Depression	Varicose Veins
Inflamation	Surgeries	Osteoporosis	General Dehydration
Joint Problems	Injuries	Denture Wearer	Edema
Stress	Skin Disorder	Pacemaker Wearer	Substance Challenged
Worry	Fear	Anger	Anxiety
Grief	Epilepsy	Chronic Fatigue	Severe Headaches
Sinus Problems	Stroke	Hearing Problem	Constipation/Diarrhea
PMS	Phlebitis/Blood Clots	Athletes Foot	Physical/Sexual Abuse

Please mark the Body Chart below.

Are there any body parts that you **would NOT like touched**? ☐ Yes ☐ No.

If yes, please ✕ the areas this applies to.

0 (Circle) the areas where you are experience **PAIN**.
Please specify level of pain from 1-10 (10 being the worst)

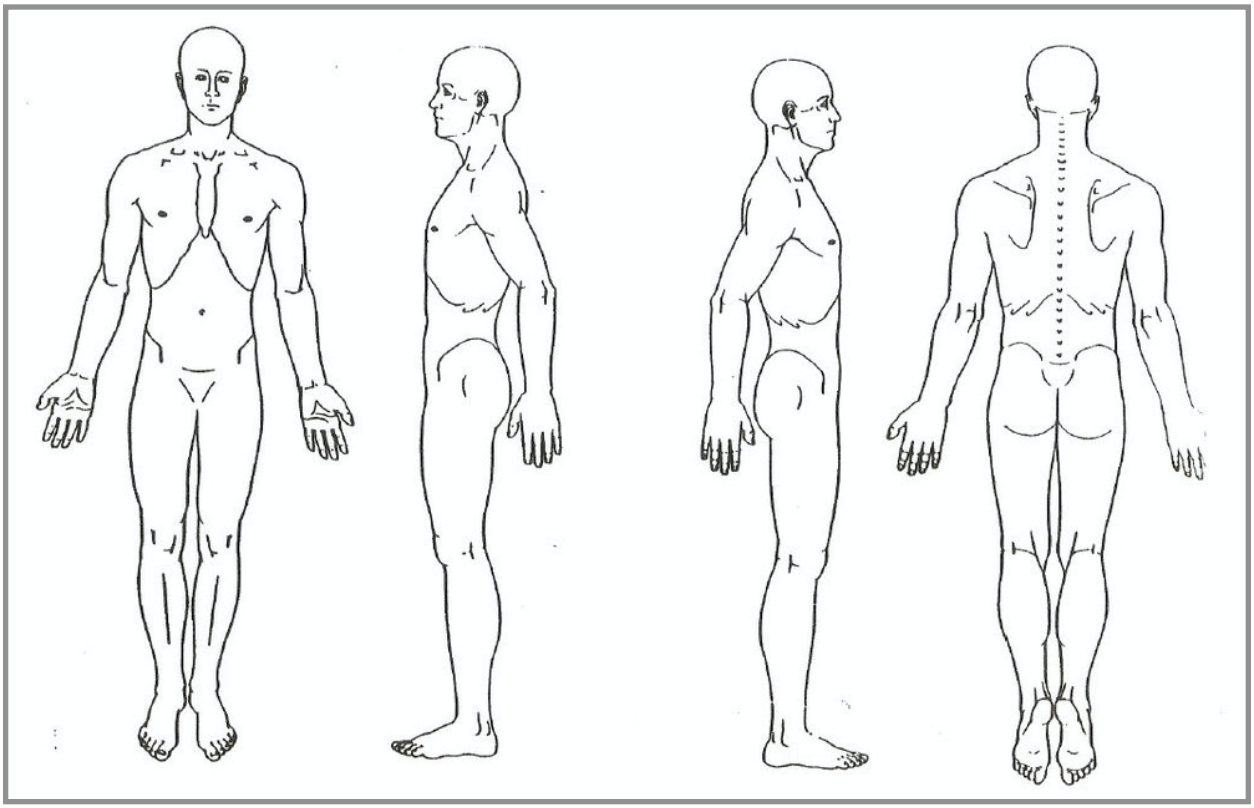
! (**Exclamation-point)** areas where you may have **OPEN WOUNDS, SCARS OR BRUISES**.

≈ **Squiggly Line** areas of **JOINT** and/or **MUSCLE STIFFNESS**

% Mark any areas of **NUMBNESS** or **TINGLING**

Is there anything else you want me to know about you, your health and/or your body that would be useful to know in order to plan a safe and effective massage session today?
☐ Yes ☐ No.

If yes, please describe:



Consent for Assessment and Treatment

I understand that the purpose of an assessment is to determine if massage therapy is advisable for me today. The nature and purpose of the assessment will be discussed and I will be given the opportunity to ask questions. Prior to the treatment I will be informed of the areas which will be treated, the proper positioning, and draping. I understand that I have the ability to refuse, alter or rescind consent at any time throughout the treatment. I understand that the massage therapist reserves the right to discontinue treatment at any point during the treatment should she see it necessary.

I understand that the massage/bodywork I receive today is provided for the basic purpose of stress reduction, relief of muscular tension/discomfort, improving circulation and enhancing my overall sense of wellness. If I experience any pain or discomfort during this session I will immediately inform the practitioner so that the heat, pressure or strokes can be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examinations, diagnosis or treatment and that I should see a qualified medical specialist for any mental or physical conditions. I understand that a massage therapist is not qualified to perform spinal or skeletal adjustments, diagnosis, prescribe or treat mental or physical illness, and that nothing said in the course of the session given should be construed as such. I understand the nature and purpose of the Massage/Bodywork and therefore give you consent to start treatment.

Signature of Client _____Date:_____

Information Consent & Personal information accuracy

I am aware that my personal information is kept disclosed and I acknowledge that I have honestly answered all questions, reviewed my information; and I accept that all information is accurate. I agree that I will inform the practitioner immediately of any changes.

Signature of Client _____Date:_____

Minor Consent for Assessment and Treatment

I_____, am the parent/legal guardian of_____.

I hereby consent for the minor/child (client) listed above to receive massage therapy treatments from Claudia Juhrs, RMT. I understand that I am financially responsible for the minor and I must schedule all appointments on their behalf. I grant permission that my child may receive treatment with or without my presence.

Signature of Parent / Legal Guardian _____Date:_____

Signature of Client _____