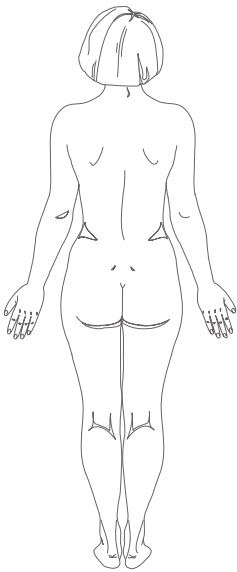
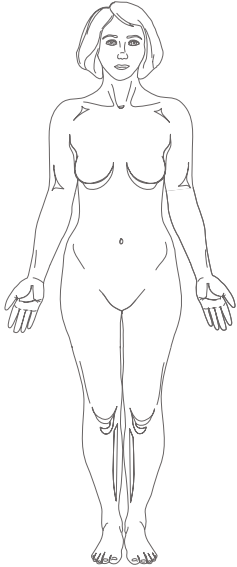




Please indicate areas of tension, pain or stress you are currently experiencing on the figures below.



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?

CLIENT INTAKE AND CONSENT FORM

Date: _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____

How did you hear about Om Land Massage? _____

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: _____

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 Eric Sirois, LMT of Om Land Massage to administer massage/bodywork to my child or dependant as they deem necessary.

Signature of Parent/Guardian: _____ Date: _____

Therapist's Signature: _____ Date: _____



Eric Sirois, LMT

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