Spirit of Lotus Therapeutic Massage Client Intake Form

Name:____
Last First MI

Address:____
Street Apt # City State Zip

Home phone:______________ Cell phone:________________ Work Phone_______________

E-mail:_______________________________________ E-Newletter Opt-In? YES NO

Date of birth:____________ Emergency contact:_______________________________________
Name Phone #

Occupation:____________________ How did you hear about us? ___________________________

Reason for appointment: ____________________ How often do you seek massage?____________
Ex. Stress relief, pain relief, headache, relaxation

Have you ever experienced a professional massage?___________ How recently?_______________

Any areas that need extra attention?____

Massage Desired: ○Deep Flow Therapeutic ○Thai Foot Massage ○Hot Stone ○Expectant Mother Massage

Check all that apply:

○ Diabetic
○ High blood pressure
○ Circulatory problems
○ Heart problems
○ Osteoporosis
○ Arthritis
○ Joint Swelling
○ Insomnia
○ Back pain
○ Migraines/Headaches
○ Varicose veins
○ Bruise easily
○ Skin problems
○ Allergies
○ Tumors/clots/cyst
○ Fibromyalgia
○ Sciatica
○ TMJ
○ AIDS/HIV+
○ Anemia
○ Stroke
○ Tension/Stress
○ Numbing/stabbing pains
○ History of Cancer

If answered "yes" to any of the above questions, please explain:
____
____

Do you frequently suffer from stress? YES NO

Have you ever had surgery? YES NO

Have you suffered any accidents or injuries in the past two (2) years? YES NO

Have you had any broken bones in the past two (2) years? YES NO

Are you pregnant? YES NO If yes, how many weeks?_________

Are you taking any medications? YES NO

Do you have any contagious illnesses? YES NO

Are you sensitive to touch or pressure anywhere? YES NO If yes, where?_________________

Is there anywhere you do not want touched? YES NO If yes, where?___________________

Do you have any implants, plates, screws, etc.? YES NO If yes, where?__________________

Please read the following statements and sign below. <u>*Signature also required on back of the form.</u>

I am aware that full draping will be used during the massage session, and I understand that it is not within the scope of the massage session for the therapist to engage in breast massage. I also understand that any illicit or sexually suggestive advances or remarks made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. I also understand that my feedback is an essential element in my treatment, therefore if at any time I should become uncomfortable during the massage, I am to bring it to the therapist's attention and request that the session end.

The massage treatment given at Spirit of Lotus is for the sole purpose of stress reduction, relief from muscle tension or spasm, and to increase circulation and energy flow. The therapist does not diagnose or prescribe for medical illness, disease, or any other physical or mental disorder. Nothing said during the session should be construed as such. The therapist does not do spinal manipulations. Massage therapy is not a substitute for medical examination or diagnosis, and it is recommended that a physician be seen for any ailment that you may have.

It is the Client's (you) responsibility to explain and discuss all physical conditions with the massage therapist.

I have read and understand this form in its entirety. If at any time there are changes in the information given, or in my condition, I will notify my therapist and update this form before receiving additional massages.

Client signature________________________ Date________ LMT signature____________________ Date________

Guidelines

Time

- Client will give a 24-hour cancellation notice otherwise the client will be billed for the session.
- A session can be lengthened based on the therapist's schedule.
- If a client shows up late for an appointment, the client will be billed for a full session and treated for the remaining time of the session. Appointments starting 15 minutes late will be rescheduled.
- If an emergency occurs for either the client or the therapist, the session may be rescheduled based on a mutual agreement.

Confidentiality

- The therapist does not share information about the session with others.
- If the client would like the therapist to send a note to a physician, the client must make the request in writing.

Treatment

- The client determines which pieces of clothing to be removed.
- The therapist discusses what is most helpful for the specific treatment; however, the client makes the final decision.
- The client determines which areas not to treat (i.e., no foot strokes due to being ticklish); likewise the therapist determines which areas not to treat (i.e., genitals, breasts).
- The client will remain covered at all times and only the area being worked on will be uncovered.
- The client needs to communicate the pain level to the therapist.
- Treatment is provided in a specific designated space that is used solely for massage and where the client's privacy is assured.
- Any person under the age of 17 years old must be accompanied by an adult during the treatment.
- If the client would like another person (i.e., spouse, friend) to observe the session, that may occur provided the person adheres to the established boundaries.
- No sexual behavior/intonation is tolerated.
- The massage therapist reserves the right to refuse treatment for any reason.

Payment

- Payment is due at the time service is rendered.
- Gift Certificates are available and are paid in advance of service; certificate to be used within a twelve month time frame.

The following are normal responses which sometimes occur during massage. You need not be embarrassed nor suppress them: Movement or release of intestinal gas – crying – laughing – strong emotions – sighing – groaning – yawning – cognitive or felt memories – stomach gurgling – the need to move or change position.

Agreement

We agree to adhere to the specified boundaries. If for some reason the client cannot adhere to the boundaries, the therapist will discuss a course of action that may result in a right to refuse treatment of the client.

Client signature ________________________________Date____________

LMT signature _________________________________Date____________

Minor Informed Consent for Massage Therapy

(For clients under 17 years of age)

I ____________________ hereby give permission (until further notice) to Neeloufar Saleh, LMT to provide my minor child/person, ____________________ under my guardianship with therapeutic massage services as deemed appropriate to treat presenting conditions/injuries. I understand that I am financially responsible for the minor, and that all statements contained in this consent apply equally to myself and to the minor.

Signed____________________Date__________ LMT__________________ Date__________

Parent/Guardian