CLIENT INTAKE INFORMATION

Address:	Name:	Referred By:		
Phone: (H)	Address:	Birth Date:		
Occupation:	City/State/Zip:	Email:	Email:	
Emergency contact — Name/Relationship/Phone: MASSAGE HISTORY/TREATMENT INFORMATION				
MASSAGE HISTORY/TREATMENT INFORMATION Have you ever received a professional massage?	Occupation:	Primary Health Ca	re Provider:	
Have you ever received a professional massage?	Emergency contact – Name/Relationsh	hip/Phone:		
What is your major reason for seeking massage therapy? Is there any region of the body you wish to not be touched? Are you currently seeing any other practitioners (Physician, Chiropractor, Acupuncture, Physical Therapist, etc.)? Yes No If yes, details: Would you like me to confer with with any of above-mentioned practitioners? List stress reduction and exercise activities, including frequency. List current medications (including OTC painkillers/supplements/herbs etc.), and reason for taking. PREVIOUS HISTORY Please include year, treatment received, and outcome. Major surgeries, accidents, injuries and hospitalizations (include sprains/strains/head injuries/broken bones): bone or joint disease cancer/tumors allergies tendinitis/-osis diabetes rashes arthritis heart condition athletes foot low back, hip, leg pain varicose veins warts neck, shoulder, arm pain high/low blood pressure digestive problems headaches lymphedema herpes/shingles spasms/cramps respiratory problems pregnant? Stage jaw pain/TMJ disorder fatigue/sleep disorders eating disorders numbness/tingling depression drug/alcohol addiction nicotine/caffeine addiction	MASSAGE HISTORY/TREAT	TMENT INFORMATION		
Is there any region of the body you wish to not be touched?	Have you ever received a professional	massage? Yes No If yes, frequency	Date of last massage	
Are you currently seeing any other practitioners (Physician, Chiropractor, Acupuncture, Physical Therapist, etc.)? Yes No If yes, details: Would you like me to confer with with any of above-mentioned practitioners? List stress reduction and exercise activities, including frequency. List current medications (including OTC painkillers/supplements/herbs etc.), and reason for taking. PREVIOUS HISTORY Please include year, treatment received, and outcome. Major surgeries, accidents, injuries and hospitalizations (include sprains/strains/head injuries/broken bones): bone or joint disease cancer/tumors allergies	What is your major reason for seeking	massage therapy?		
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Details about above conditions or additional medical conditions/concerns?	jaw pain/TMJ disorder	fatigue/sleep disorders	eating disorders	
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Consent Form

Liz Stefany, Licensed Massage Therapist ME License # MT4220

- It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow.
- I understand that licensed massage therapists do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations.
- I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.
- If I experience any pain or discomfort during this or future massage therapy session(s), I will immediately inform the practitioner so that the pressure and/or techniques may be adjusted to my comfort level.
- I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for full payment for the scheduled appointment.
- I understand that bodywork is contraindicated under certain medical conditions and I will update the massage therapist of any changes in my medical profile. I understand that there will be no liability on the practitioner's part should I fail to do so.
- I have accurately stated all current and past medical conditions of which I am aware on this intake form.

Client Signature:	Date:
CONSENT TO TREATMENT OF A MINOR: I hereby authorize the ab provide my minor child/person under my guardianship with therap appropriate to treat presenting conditions/injuries. I understand t responsible for the minor, and that all statements contained in this and to the minor.	peutic massage as deemed hat I am financially
Parent/Guardian Name:	
Parent/Guardian Signature:	_ Date:
My child/charge has my permission to appear for treatment in my	absence: Initials