TRIPLE H CLINIC
Holistic Health and Healing
of Winding Waters

Massage Client Intake Form

Name_____
Occupation: _____

Referred By: _____

Medical Information (Allergies, conditions, disorders, surgeries, etc.):

_____

Last massage if applicable _____

Do you exercise and stretch? Yes No

If so what type of stretching and exercise?_____

What is your goal for this massage_____

Are you sensitive to essential oils? _____

Do you have sensitive skin? _____ Do you smoke? _____

Pressure (deep, medium, light): _____

Are you currently under medical supervision? Yes No

Are you currently taking any medication? Yes No

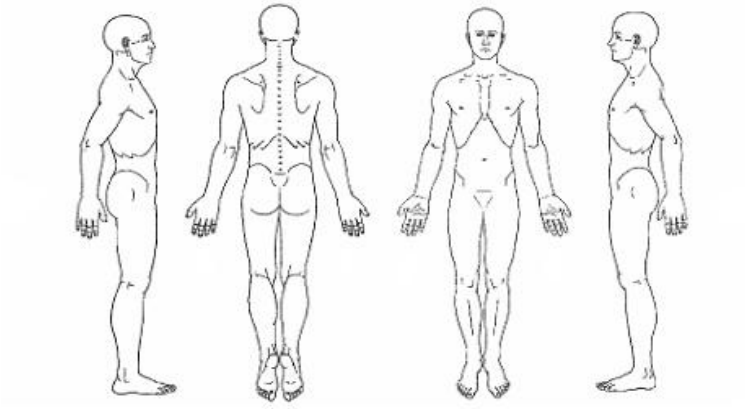
Are you pregnant? Yes No If yes, how many months? _____

Please check any condition listed below that applies to you:

( ) Contagious skin condition
( ) Easy Bruising
( ) Recent fracture
( ) Deep vein thrombosis/blood clots
( ) Osteoporosis
( ) Headaches/Migraines
( ) Diabetes
( ) Back/neck problems
( ) Open sores or wounds
( ) Recent accident or injury
( ) Phlebitis
( ) Joint disorder: _____
( ) Epilepsy
( ) Cancer: _____
( ) Decreased sensation
( ) Fibromyalgia

( ) TMJ ( ) Carpal Tunnel Syndrome

Circle any specific areas where you experience pain or need focus on



I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/body-work practitioners are not qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also 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 payment of the scheduled appointment.

I understand that all treatments at this facility are therapeutic in nature. I agree to notify the therapist of any physical discomfort or draping issues during the session. This facility has provided me with information on Massage Cupping bodywork technique. If I choose to experience this therapy in my treatment, I understand the effects and after-care recommendations. It has been explained to me that there is the possibility of a skin discoloration, or "cup kiss," appearing as tissue is released. I am aware that a "cup kiss" is not a bruise and that it will dissipate within a few hours to a few days.

I am also aware that *fire cupping* technique is not covered under my therapist's professional liability insurance. This facility and the therapist will not be held liable for any indications that arise during or after the treatment. I agree to notify the therapist should any such indications occur. I have stated all relevant physical conditions and will inform the therapist of any changes in my health when they arise.

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

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