Judy Lucas, LMT
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Client Intake Form

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Client Signature

Personal Information

Name Date of Birth

Address

City State Zip

Home phone Cell Phone

Email

Occupation

Referred By

Emergency Contact Name (Relationship) Emergency Contact Phone

Physician's Name Physician's Phone

Massage Experience

Have you had a professional massage before? ☐ Yes ☐ No
If yes, what types of massage have you had (Swedish, shiatsu, deep tissue, etc.)?

How long have you been receiving massage therapy?

Frequency of massages?

When was your last massage?

What are your goals for treatment?

List any known allergies:

Date of Initial Visit

Current Health

Reason for initial visit:

Height & Weight:

Do you exercise regularly and/or participate in any sports?
☐ Y ☐ N
If yes, describe:

Do you perform any repetitive movement in your work, sports or hobby?
☐ Y ☐ N
If yes, describe:

Do you sit for long hours at a workstation, computer or driving?
☐ Y ☐ N
If yes, describe:

Do you experience stress in your work, family, or other aspects of your life?
☐ Y ☐ N
If yes, describe:

Are you experiencing tension, stiffness, discomfort, or pain?
☐ Y ☐ N
If yes, describe:

Have you recently had an injury, surgery, or areas of inflammation?
☐ Y ☐ N
If yes, describe:

Are you currently under medical care?
☐ Y ☐ N

Do you have sensitive skin?
☐ Y ☐ N

Do you have allergies or sensitivities to oils or lotions?
☐ Y ☐ N
If yes, describe:

List any medications you are currently taking

Health History (select all that apply)

Neck/back pain
Sprains/strains
Carpal Tunnel Syndrome
Thoracic Outlet Syndrome
Fibromyalgia
Bone/joint disease
Tendonitis/bursitis
Jaw Pain (TMJ)
Heart condition
Phlebitis/varicose veins
Blood clots
High/low blood pressure

Lymphedema
Thrombosis/embolism
Breathing difficulty
Asthma
Emphysema
Sinus Problems
Numbness/tingling
Pinched Nerve
Chronic Pain
Paralysis
Currently Pregnant
Ovarian/menstrual Issues

Prostate
Rashes
Cosmetic surgery
Athlete's foot
Irritable Bowel Syndrome
Bladder/kidney Ailment
Colitis/Crohn's Disease
Ulcers
Anxiety/stress
Depression
Cancer/tumors
Significant trauma

Diabetes
Migraines/headaches
Dizziness
Jaw clicks
Teeth grinding
Drug/alcohol/tobacco use
Contact lenses
Dentures
Hearing aids
Sleep disturbances
Cold hands/feet
Bleed/bruise easily

Please explain any of the conditions that you have marked above:

Any other medical condition(s) not listed:

Client Agreement

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments.

I understand that the massage I receive is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension. If I experience any pain during this session, I will immediately inform the massage therapist so that work can be adjusted to my level of comfort.

Because massage can be harmful 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 massage therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the part of Judy Lucas or Heart Through Hands should I forget to do so.

I acknowledge that massage therapy should not be used as a substitute for medical examination, diagnosis, or treatment and that if I am aware of any mental or physical ailment I should see a physician, chiropractor, or other qualified medical specialist. I am aware that the massage therapist does not diagnose illness or disease nor prescribe medications. I have stated all medical and physical conditions and medications that I am aware of, and will inform my practitioner of any changes in my health status. I agree that if I experience any pain or discomfort during the session, I will immediately communicate that to the therapist so the treatment can be adjusted. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

It is also understood 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 for the full scheduled appointment.

I have carefully read and understand all of the above and I have answered all questions fully and accurately.

_____

Name (print)

_____

Signature date

Assignment of Benefits

I am responsible for all charges for all service provided. I understand that payment is due at the time of service. Should I need to cancel future sessions, I agree to give a 24-hour notice or I will be financially responsible for the session time.

_____

Name (print)

_____

Signature date

Heart through Hands