Client Intake Form and Liability Waiver – Page 1

Name _____ Phone (_____) _____ DOB _____

Address _____ City _____ State _____ Zip _____

Email _____ ☐ Yes, Please include me on your mailing list

Referred by _____ Phone (_____) _____

In case of emergency _____ Phone (_____) _____

Occupation _____ Sex ☐ Male ☐ Female

Physician_____ Phone (_____) _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever received a professional massage before? ☐ Yes ☐ No How Recently?_____

What are your goals for today's session? _____

What kind of pressure do you prefer? ☐ Light ☐ Medium ☐ Deep ☐ Other _____

Do you currently have or have you ever experienced any of the following symptoms? Please Explain.

☐ Yes ☐ No - Allergies	☐ Yes ☐ No - Arthritis	☐ Yes ☐ No - Asthma
☐ Yes ☐ No - Back Pain	☐ Yes ☐ No - Bruise Easily	☐ Yes ☐ No - Diabetes
☐ Yes ☐ No - Cancer	☐ Yes ☐ No - Contagious Disease	☐ Yes ☐ No - Heart Disease
☐ Yes ☐ No - Eczema	☐ Yes ☐ No - Freq. Headaches	☐ Yes ☐ No - Joint Swelling
☐ Yes ☐ No - High Blood Pressure	☐ Yes ☐ No - Instrumentation	☐ Yes ☐ No - Osteoporosis
☐ Yes ☐ No - Kidney Disease	☐ Yes ☐ No - Lung Disease	☐ Yes ☐ No - Varicose Veins
☐ Yes ☐ No - Seizures/Epilepsy	☐ Yes ☐ No - Thyroid Disorder	

Please describe any Injuries or Broken Bones in the last 2 years? _____

_____

Have you had any Major Surgeries and when? _____

_____

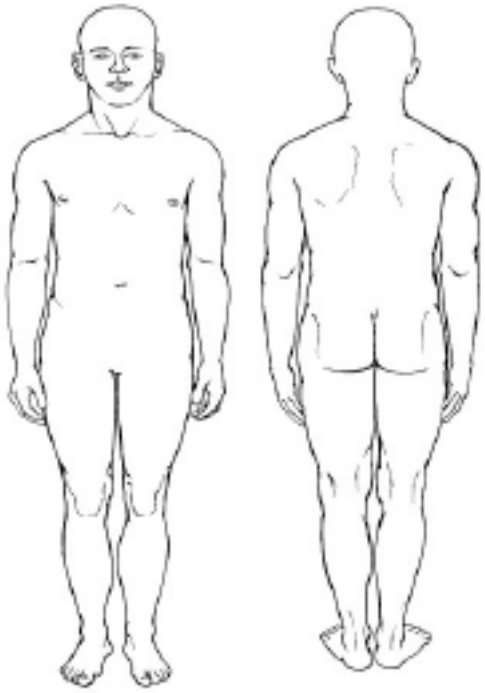
If you are currently taking any Medications, please describe. _____

_____

Females: Are you Pregnant? ☐ Yes ☐ No If yes, which Trimester? ☐ First ☐ Second ☐ Third

On the figure to the right, please mark any areas of:

T = Tension
S = Soreness
N = Numbness
P = Pain



Please feel free to explain your symptoms, as necessary:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Liability Waiver

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 of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or tr eat 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 the client will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____

Consent to Treatment of a Minor

By my signature below, I hereby authorize _____ to receive therapeutic massage and body work treatments from a qualified therapist of Postureworks Medical Massage, as they deem necessary.

Parent or Guardian Signature _____ Date _____

Consent Addendums:

Application of therapeutic massage techniques may be made to all areas of the body with the exception of the genital area. It is important to note that there are other areas of the body that, though they can be legitimately accessed for therapeutic reasons, may be sensitive in some manner for the client. The following consent waivers are for those regions of the body that can be, but are not considered part of a standard fullbody massage therapy. The following waivers are only valid in conjunction with a properly signed “Liability Waiver" as found on the previous page.

Consent for massage therapy to the gluteal and deep hip rotator muscle (buttock) area

This area includes the soft tissue from the gluteal cleft, moving lateral to the tensor fascia lata, superior margin is the iliac crest and the inferior margin is to the ischial tuberosity. Draping is performed to expose this area yet leave the genital area covered. The massage therapist has discussed with me issues involving massage therapy for the buttock and hip area to my satisfaction. Due to the sensitive nature of gluteal and deep hip rotator muscle massage, the therapist and the client each retain the right to immediately modify or terminate treatment for any reason. I freely give my permission to receive massage therapy treatment to the buttock and hip area.

Client (or guardian): _____ Date: _____

Therapist: _____ Date: _____

Consent for massage therapy to the abdominal region

This area includes the soft tissue superior to an imaginary line drawn from the left AIIS to right AIIS of the client and inferior to the tissue of the female breasts and/or the fifth (5) rib. This area also includes anterior access to the psoas and iliacus muscles within the pelvic girdle. Due to the sensitive nature of massaging the abdominal area, the therapist and the client each retain the right to immediately modify or terminate treatment for any reason. The massage therapist has discussed with me issues involving massage therapy for the abdominal region to my satisfaction. I freely give my permission to receive abdominal massage therapy.

Client (or guardian): _____ Date: _____

Therapist: _____ Date: _____

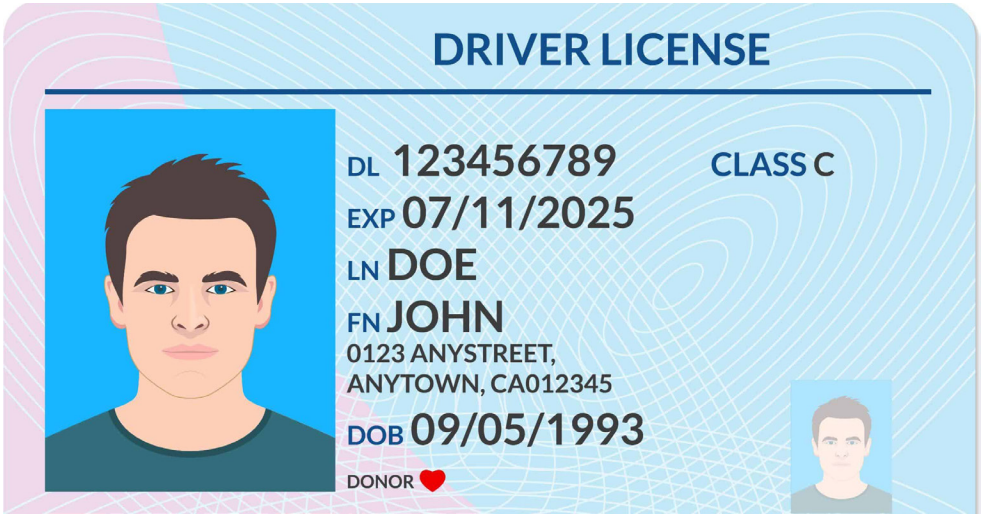
Consent for breast massage therapy (females only)

This area includes the soft tissue of the breast including extensions of breast tissue to the axilla (arm pit region), lower edge of the clavicle, sternal mid-line and the anterior edge of the latissimus dorsi. Breast massage does not include touching the nipple of the breast. Due to the sensitive nature of breast massage, the therapist and the client each retain the right to immediately modify or terminate treatment for any reason. The massage therapist has discussed with me issues involving breast massage therapy to my satisfaction. I freely give my permission to receive breast massage therapy.

Client (or guardian): _____ Date: _____

Therapist: _____ Date: _____

Please print and attach a copy of your drivers license or passport image here.



Please email this completed form to ashley.postureworks@gmail.com.