

Metta Thai Therapeutic Massage

Client Health Intake Form

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____ E-mail: _____

Occupation: _____ M / F Date of Birth: _____

Emergency Contact Person: _____ Phone: _____

Have you received a massage before? Yes No Many times if yes, when: _____

How did you hear about us? _____ Referred By: _____

Are you currently under a physician's care? Yes No what condition(s): _____

Who is your health care provider: _____

Are you currently taking any prescribed medications or dietary supplements? Yes No

If yes, please list: _____

Please list any painful or tense areas as well as regions that you tend to hold your stress:

Please mark an (X) by all medical conditions/symptoms that you have/ had in the past year:

- | | | |
|--|--|---|
| <input type="checkbox"/> Abdominal /digestive problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Edema/Swelling/Inflammation | <input type="checkbox"/> Rash/fungus |
| <input type="checkbox"/> Arthritis/tendonitis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Asthma or lung condition | <input type="checkbox"/> Headaches, migraine | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Athletes foot | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sleep difficulties |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Spinal disorders |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Sprain/strain |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Circulatory/heart problems | <input type="checkbox"/> Muscle/bone injuries | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Constipation/diarrhea | <input type="checkbox"/> Muscle/joint pain | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Other _____ |

Allergies: _____

Elaborate on noted areas above: _____

Please list any recent injuries or surgeries within the past 5 years: _____

Please list your stress-reduction activities, hobbies, exercise and/or sport participation: _____

Please use the letters provided in the key to identify the symptoms you are feeling today. Circle the area around each letter, representing the size and shape of each symptom location.

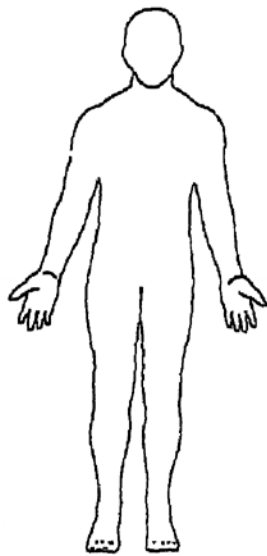
P= pain or tenderness

S= joint or muscle stiffness

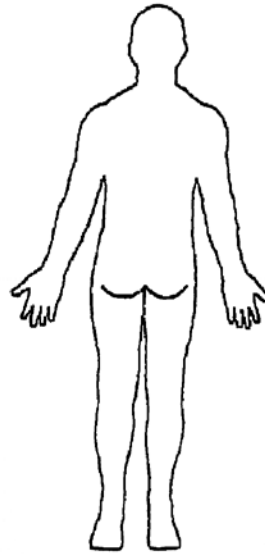
N= numbness or tingling



Right



Front



Back



Left

I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I will inform my health care provider and massage therapist if anything changes in my status. I understand that massage or bodywork I receive is for the purpose of stress reduction and the relief from muscular tension, spasm or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform my massage therapist so that the pressure and/or methods can be adjusted to my comfort level. I understand that my massage therapist does not diagnose illness or disease, nor perform any spinal manipulations, and does not prescribe any medications/treatments. I acknowledge that massage is not a substitute for a medical examination or diagnosis and that I should see my health care provider for those services. If I am unable to attend my scheduled appointment, I will respect and abide by the set cancellation policies. Sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated. I understand that I am receiving massage therapy at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy I hereby hold harmless and indemnify the therapist from all claims and liability whatsoever.

Client Signature: _____

Date: _____

Metta Thai Therapeutic Massage

92 High Street Unit B3, Medford MA 02155

Office Policies

Cancelled, Missed or Late Appointment

- If you cannot attend your scheduled appointment, you must call to cancel 24 hours in advance or be charged the full fee for your service or forfeit your gift certificate (whichever applies).
- Additionally, if you miss your scheduled appointment, you will be charged the full fee for your service.
- If you are more than 15 minutes late for your appointment and you have not called to let us know you are running late, you will forfeit your session and be charged the full fee for your service.
- During the winter months please provide as much advance notice as possible if you decide to cancel your appointment due to inclement weather or announced state of emergencies.
- The 24-hour cancellation policy does not apply to weather related cancellations.
- If you have a cold, fever or the flu, please call to reschedule your appointment. Having a massage while you are sick just spreads the infection and it is best to get the rest you need.

Confirming Appointments

It is my policy to only confirm an appointment for new clients on their first visit. If you require a reminder call the day before your scheduled appointment, please let me know.

Paying for your session

Payments can be made in cash or check only and are due at the time of your appointment.

Client Referral Program

For every new client you refer, you will receive \$10 off your next one-hour massage. Gift Certificates purchased for others do not constitute a "referral" and are not eligible for this discount. Discounts cannot be combined with other specials, promotions, etc.

I have read and understand the above-mentioned office policies.

Client Signature _____

Date _____

I would like to receive your newsletters and emails regarding events, promotions, etc.

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Client Consent for the Purposes of Treatment and Payment

I, _____, give consent to _____ for the purposes of providing treatment and receiving payment for services rendered to me. I understand that massage or bodywork I receive is for the purpose of stress reduction and the relief from muscular tension, spasm or pain and to increase circulation. I understand that my massage therapist does not diagnose illness or disease nor perform any spinal manipulations, and does not prescribe any medications or treatments. I acknowledge that massage is not a substitute for a medical examination or diagnosis and that I should see my health care provider for those services.

I have received a copy of the Office Policies. I have read and understand. If I am unable to attend my scheduled appointment, I will respect and abide by the set cancellation policies.

Sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated.

I understand that I am receiving massage therapy at my own risk. I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy I hereby hold harmless and indemnify the therapist from all claims and liability whatsoever.

Client Signature: _____ Date: _____

Print Client Name: _____ Date: _____

You may contact me for appointment reminders, schedule changes, or other needs by the following methods (fill in only those methods by which you desire to be contacted):

Home telephone: _____ Work Telephone: _____

Cell Phone: _____ E-mail: _____

Home Address: _____ Work Address: _____

City _____

City _____

State/Province _____ Postal Code: _____

State/Province _____ Postal Code: _____