

A Touch Of Solitude

CLIENT INTAKE FORM

(Print) NAME _____ *

TODAY'S DATE _____ *

ADDRESS _____ *

HOME _____

WORK _____

CELL _____ *

E-MAIL _____ *

Lic# _____ * Show of license
required (Massages are not offered to anonymous clients)

Name in facebook: _____

Credit Card Info: ___ Visa ___ MasterCard ___ Discover Number _____ *

(necessary to secure future appointments)

Expires _____ *

REFERRED BY _____

CURRENT CONDITIONS / MEDICAL HISTORY

Age: _____ Birth date: _____ Male / Female

Occupation: _____ married / single How many children: _____

incase of emergency notify _____ Phone number _____

Have you received a massage before? YES NO Date of last _____

What type? SWEDISH SPORTS DEEP TISSUE ROM OTHER _____

Please indicate your stress level: (5 being the highest) 1 2 3 4 5

To assure your comfort, lessen the chance of injury, and to determine the massage that suits your needs, please list any accidents / surgeries you have ever had.

Date _____

Date _____

To better suit your needs please indicated the reason for today's session: _____

Please list all the conditions that you are currently under the care of a physician.

Please list all medications. This will help determine if they are contraindicated to a massage.

How much alcohol have you had today? _____

Smoke? YES NO

Due you prefer to have a conversation during your massage? ___ Yes ___ No ___ doesn't matter to me

PLEASE TAKE THE TIME

-Allergies
-Arthritis
-Asthma
-Back Pain
-Bursitis
-Cancer
-Car Accidents
-Carpal Tunnel
-Chest Pains
-Circulatory Problems
-Dislocations
-Decreased ROM
-Diabetes
-Digestive Disorders
-Dizziness
-Edema
-Fatigue
-Fibromyalgia
-Fractures
-Fainting Spells
-Gout
-Headaches
-Heart Conditions
-Herniated Discs
-HIV / AIDS
-Insomnia
-Loss of Balance
-Low/High Blood Pres.
-Muscle Sprain
-Neck Pain
-Nerve Damage
-Pins
-Pacemaker
-Pregnant
-Lyme Disease
-Sciatica
-Seizures
-Shortness of Breath
-Sinusitis
-Skin Problem
-Spinal Disorders
-Sports Injury
-Stress
-Surgeries
-Tendonitis
-TMJ
-Ulcers
-Varicose Veins

....other

please explain

It is normal for clients to experience muscles soreness a day or two after a blissful massage. A massage releases toxins from the muscles which causes the muscle to ache. This is more common for those who do not receive massages on a regular basis and for those clients not in touch with there body's functions of normal muscle aches . This is also true for those who have not experienced Evangeline's massage technique that is being used. The soreness like feeling will subside after a day leaving you more mobile no need to panic. Call A Touch of Solitude with any questions or concerns. It is also normal to feel a tight ache in your lower back after the massage due to the long period of the straight laying position. Ask for a pillow under the abdomen. The client shall take full responsibility for any loss, injury, or damages. _____ initials

WAIVER / INFORMED CONSENT

I _____ Understand that massage therapy provided by A Touch of Solitude is intended to: enhance relaxation, release muscle tension or spasm, increase range of motion, and improve circulation or energy flow. I understand the Holistic Healers do not diagnose illness or disease, do not prescribe medications, and do not perform spinal manipulation. I understand that Alternative Medicine is not a substitute for medical treatment or for medications and it is recommended I see a physician for any ailment I may have. I will provide the Holistic Healer with any physician's medical release when needed. In situations where a physician's medical release is requested by A Touch of Solitude; and the client refuses and / or is unable to provide it to the Holistic Healer, the Holistic Healer has the right to refuse services until further notice. I have informed the Holistic Healer of all my known physical conditions, medical conditions, medications and an accurate amount of alcohol intake. I will keep the Holistic Healer updated on any changes per each visit. The client shall take full responsibility for any loss, injury, or damages. I understand missed appointments, or late cancellations, or thereof combined is my sole responsibility and not of ATOS and is subject to fees of at least fifty percent of the session that was scheduled. Signing below is assuring that I understand that I must give at least twenty four (24) hours notice of all cancellations as required or I will be subject to fees of fifty percent (or more in fewer cases) of the scheduled session plus any dues owed. I understand what I read and I agree to pay that amount. I fully understand that sexual remarks or gestures will result in the immediate termination of the session and I will be required to pay in full for the entire session prior to leaving the premises.

Signature _____ Date: _____

Print Name _____