Massage Intake Form

ESSENTIAL BODYWORK THERAPY

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: _____

_____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain _____

What makes it better? _____

_____

What makes it worse? _____

_____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: _____

Please indicate any of the following that apply to you.

- ☐ Cancer
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement(s)
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Heart Attack
- ☐ Kidney Dysfunction
- ☐ Blood Clots
- ☐ Numbness
- ☐ Sprains or Strains

Explain any conditions you have marked above:

_____

_____

_____

_____

Massage Information

Have you had a professional massage before? ☐ yes ☐ no

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

Other _____

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain _____

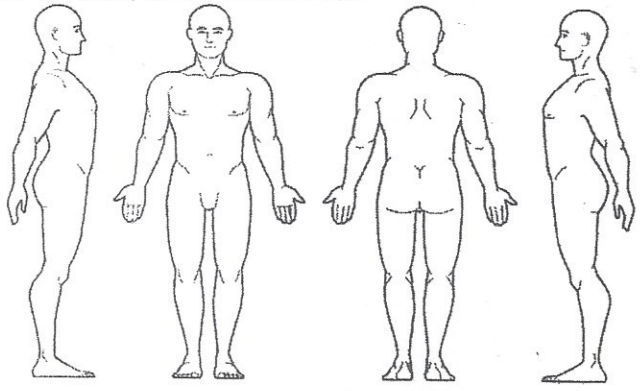
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



By signing below, you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ *Date* _____

Therapist Signature _____ *Date* _____

Cupping Therapy Client Release Form

- I understand that all treatments at this facility are therapeutic in nature. I agree to communicate to the therapist any physical discomfort or draping issues during the session.
- Information has been provided to me about Cupping Therapy. If I choose to experience these therapies during treatments, I understand the potential effects and after-care recommendations.
- It has been explained to me that there are contraindications for Cupping Therapy. I have fully disclosed all health factors to my therapist, including those not mentioned on my Health History Intake Form, to avoid any complications.
- It has been explained to me that there is the possibility of discolorations that can occur from the release and clearing of stagnation and toxins from my body.
- I also understand that this reaction is not bruising, but due to cellular debris, pathogenic factors and toxins being drawn to the surface to be clear away by my circulatory systems.
- I further understand that the discolorations will dissipate from a few hours to as long as 2 weeks in some cases and in relation to my after-care activities.
- I understand that the first time I experience Cupping, my body's immune system can temporarily react to this release as it might with the flu – producing flu-like effects like nausea, headache, aches, that will subside in time with rest and water. Water helps to dilute the intensity of the release.
- I understand that Cupping Therapy modalities should not be combined with aggressive exfoliation, 4 hrs after shaving, after sunburn or when I'm hungry or thirsty.
- I understand that I should avoid exposure to cold, wet, and/or windy weather conditions, hot showers, baths, saunas, hot tubs and aggressive exercise for 4 - 6 hours. I understand that exposure to such extremes can produce undesirable effects and I should avoid such situations.
- I understand that I should avoid caffeine, alcohol, sugary foods and drinks, dairy and processed meats and I should consume an abundance of clean water.

I _____ agree to allow the Cupping Practitioner to perform Cupping. I also agree that I have read, understand and will follow all of the information stated above and will not hold the practitioner responsible.

Date_____ Signature of Client _____

Print Name _____

Date_____ Signature of Practitioner _____

Print Name _____

Bio Therapy DDS Informed Consent Form

Please initial that you understand each section

___ I understand that the DDS therapy given to me, is for the purpose of stress reduction, pain reduction, relief from muscle tension, and/or increasing circulation.

___I understand that the therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of the therapy.

___I understand that this therapy is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have.

___The following conditions may prevent you from utilizing this therapy, update your therapist.

Please circle any medical conditions you may have:

- Thrombosis
- Phlebitis
- Hypertension higher than 160/110 mmHg
- High Anxiety meds
- Lung/Kidney Failure
- Acute infectious Diseases
- Osteoporosis
- Angina
- Pacemakers
- Epilepsy
- Pinched Nerves
- Fracture
- Metal/Silicone implants
- Pregnancy
- Menstruation
- Hemorrhagic disease
- Psoriasis/Eczema
- High Blood Pressure
- Cancer
- Heart problems/failure
- Nervous/Psychotic Conditions
- Diabetes
- Malignancy
- Other Serious Condition

By signing this release form, I waive and release my therapist and DDS Bio Therapy from any and all liability relating to this session.

Print Name: _____ Signature: _____ Date: _____