

# Massage Intake Form

Living Tree Center for Healing

Date: \_\_\_\_\_

**Industry Standard for massage is 50 minutes hands on time / 90 minutes – 75 minutes hands on**  
**Tardy Policy:** Please be respectful of time frame. The time has been specifically reserved for you, and if you are late, your appointment will be shortened.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Are you a patient at Living Tree? Y | N  Chiropractic  Acupuncture/Cupping  Nutritional

What is your goal for today? (choose one):  Relaxation  Pain Relief  Both

What areas can we *focus on* today? (Ex: Back, Legs) \_\_\_\_\_

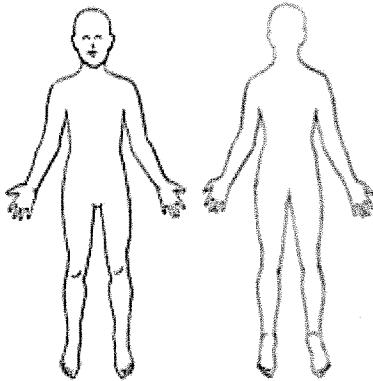
Any areas to *avoid* : (Ex: Face, Feet) \_\_\_\_\_

Are you pregnant (must be past 1<sup>st</sup> trimester?) Y | N Expected Due Date: \_\_\_\_\_

Any injuries, accidents or illnesses? Y | N Please explain: \_\_\_\_\_

Please indicate any present or past conditions:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Headaches /Migraines              | <input type="checkbox"/> Stress / Fatigue | <input type="checkbox"/> Knee Pain                       |
| <input type="checkbox"/> Low Back / Sciatic                | <input type="checkbox"/> Fibromyalgia     | <input type="checkbox"/> Foot Pain / Plantar Fasciitis   |
| <input type="checkbox"/> Varicose Veins                    | <input type="checkbox"/> Neck Pain        | <input type="checkbox"/> Arm / Elbow Pain                |
| <input type="checkbox"/> Cramps / Spasms<br>(Leg, back...) | <input type="checkbox"/> Mid Back Pain    | <input type="checkbox"/> Carpal Tunnel                   |
| <input type="checkbox"/> Sinus Issues                      | <input type="checkbox"/> Hip Pain         | <input type="checkbox"/> Numbness / Tingling<br>in Hands |
| <input type="checkbox"/> Allergies                         | <input type="checkbox"/> Leg Pain         | <input type="checkbox"/> Other _____                     |



Please Identify any of the Problem Areas  
You Experience on the diagram shown.  
**Please list any Underlying Medical Conditions**

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## Release Form

I have completed the massage intake form and all information is true and correct.

I understand that draping will be used during the session – only the area being worked on will be uncovered.

Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by a parent or legal guardian for any client under the age of 18.

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. By signing this, I agree that I have answered all questions to the best of my knowledge and that I will inform the therapist of any changes in my condition or medication. If I experience any pain/discomfort or would like the pressure adjusted, I will inform the therapist immediately.

I understand that a massage therapist cannot diagnose any illness, disease, or any physical or mental disorders nor can the therapist prescribe any medication and that nothing said in a session should be construed as such. I understand the massage therapy is intended to work in conjunction with my health care, not act as a substitute for medical examination. I understand that it is my responsibility to consult a physician for any ailments I may have.

I agree that I am of legal age (18 years old) and that if I am not, I agree to have my parent or guardian sign the parental/guardian release form before treatment. In addition to the information contained in the massage intake form, I have made the therapist aware of any conditions or concerns I may have. Failure to make such disclosure may result in harm or injury.

I understand that certain conditions or medications may not permit massage or may require the use of alternate techniques or pressure. I respect the decision of the massage therapist and am fully prepared to reschedule that massage for a later date if requested by the massage therapist. I also understand that massage may be advisable by my physician, but not a massage therapist. In that event, I agree to provide a written agreement from my physician before proceeding with treatment.

I understand Living Tree Center for Healing and Felicia Williams have a Zero Tolerance Policy for inappropriate behavior. A session will end immediately without refund.

In consideration for Living Tree Center for Healing and Felicia Williams providing this special accommodation, the undersigned, in addition to paying the stated fee, agrees that the undersigned releases and shall hold Felicia Williams, Living Tree Center for Healing, its agents, employees, owners and officers harmless from any claims for injury or damage arising from either the performance or nonperformance of some part of the procedure. The undersigned recognizes without this statement of release, Living Tree Center for Healing and Felicia Williams would not provide the service.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Parent or Guardian (under 18 years old) \_\_\_\_\_

Date: \_\_\_\_\_

### ADMINISTRATIVE AREA

Date _____ Session # _____ S: _____ O: _____ A: _____ P: _____	Date _____ Session # _____ S: _____ O: _____ A: _____ P: _____
