

On the chart below, use an "X" to mark bruises, cuts, painful or ticklish areas to avoid during your massage. Circle areas of tension, and those needing extra work.

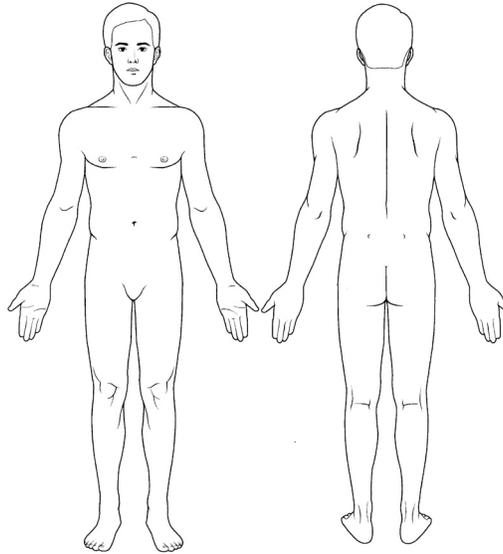


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**BY SIGNING BELOW I CONFIRM THAT I UNDERSTAND AND AGREE WITH THE FOLLOWING:**

If I become uncomfortable or experience any pain during the massage, I may ask the massage therapist to adjust the pressure and/or strokes to my comfort or to stop the massage, and she will then end the session.

The massage I will receive is a blend of Swedish, Deep Tissue, Trigger Point, Reflexology, Joint Range of Motion Techniques and Stretching applied to soft tissues of the back, buttocks, thighs, calves, feet, shoulders, arms, hands, head, scalp, face, ears, neck, and chest/pectorals—except any areas to avoid as noted above.

Indications (reasons) for massage are stress, pain in the muscles, muscle soreness, muscular spasms; and pain in the joints, pain in the hands or feet; and tension headaches and migraines.

Contraindications to receiving massage are abnormal body temperature, acute infectious disease, inflammation, osteoporosis, varicose veins, blood clots, swelling, high or low blood pressure, cancer, intoxication, skin problems, hernia and other conditions as listed above.

The massage therapy I will receive is for the purpose of stress reduction, relief from muscular tension or spasm or for increasing circulation. It is not a substitute for medical treatment. The massage therapist does not diagnose illness, disease or any other physical or mental disorders, and does not prescribe treatment.

My privacy and body will be respected at all times. Proper draping will be observed at all times for my comfort, security and warmth (draping is the use of a sheet to cover all but the body area being massaged.)

There will be no breast massage of a female client without her written consent.

*There will be NO massage performed on any private areas of my body.*

**The information I have provided on this form concerning my state of health and my medical history is accurate and complete. I freely give my permission to be massaged. By signing this form, I also give consent for future sessions. If I miss a scheduled appointment without giving 24 hour notice I agree to pay full missed appointment(s) fee. Do you have any other medical conditions that I should be aware of before receiving your massage?**

**If YES, please specify \_\_\_\_\_**

Client Signature

Date

Massage Therapist

Date



**Just Relax & Renew**  
**Heidi Coker TX LMT#105825**

**CONFIDENTIAL THERAPEUTIC MASSAGE THERAPY CLIENT HEALTH INTAKE FORM**

NAME \_\_\_\_\_ BIRTHDAY \_\_\_/\_\_\_/\_\_\_ DATE \_\_\_/\_\_\_/\_\_\_  
 ADDRESS \_\_\_\_\_ CITY/STATE/ZIP \_\_\_\_\_  
 HOME PHONE( ) \_\_\_\_\_ WORK( ) \_\_\_\_\_ CELL( ) \_\_\_\_\_  
 OCCUPATION/EMPLOYER \_\_\_\_\_ E-MAIL \_\_\_\_\_  
 REFERRED BY \_\_\_\_\_ REASON FOR APPOINTMENT \_\_\_\_\_  
 Have you had a professional massage before? Y/N When \_\_\_\_\_ By whom \_\_\_\_\_  
 What did you like/dislike about your previous massage session? \_\_\_\_\_  
 Are you currently under the care of a physician and/or a chiropractor for any reason? Y/N  
 If yes, please explain \_\_\_\_\_  
 Are you currently on any prescribed or OTC medications? Y/N  
 List \_\_\_\_\_

Place a checkmark beside the conditions you are currently experiencing:

- |                        |     |   |     |
|------------------------|-----|---|-----|
| Pregnancy/Nursing      | ___ | High or Low Blood Pressure                | ___ |
| Osteoporosis           | ___ | Fibromyalgia                              | ___ |
| Skin Allergies         | ___ | Multiple Sclerosis                        | ___ |
| Tendonitis or Bursitis | ___ | Cancer/Tumor(s)(past or present)          | ___ |
| Carpal Tunnel          | ___ | Allergies/Sinus/Respiratory Condition     | ___ |
| Scoliosis/H-Rod        | ___ | Seizures/Convulsions/Epileptic Disorder   | ___ |
| Phlebitis/Blood Clots  | ___ | Migraines/ Headaches/Whiplash             | ___ |
| Diabetes               | ___ | Contagious or Infectious Condition        | ___ |
| HIV/Aids Positive      | ___ | Heart Disease or Circulatory Problems     | ___ |
| Varicose/Spider Veins  | ___ | Herniated/Ruptured/Bulging Disc           | ___ |
| Swelling/Bruise Easily | ___ | Facial Reconstruction/Injections/Implants | ___ |
| Spinal Problems        | ___ | Dentures/Contact Lenses/Hearing Aids      | ___ |
| Chronic Pain/Fatigue   | ___ | Elevated Cholesterol                      | ___ |
| Stress/Tension/Anxiety | ___ | Low Back Pain/Sciatica                    | ___ |
| Pinched Nerve/Numbness | ___ | Arthritis/Rheumatoid/Osteoarthritis       | ___ |

Any other medically supervised condition(s)? \_\_\_\_\_

List previous Surgeries, Implants, and/or including Pacemaker \_\_\_\_\_

Suffered Accident, MVA, or Injury within the last 2 years? \_\_\_\_\_