MS 0016
THE LAUTERSTEIN-CONWAY MASSAGE SCHOOL & CLINIC
www.TLCschool.com

Client Intake Form

Date: _____

Name _____ Preferred Phone: _____m/h/w

Address _____ Alternate Phone: _____ m/h/w

City _____ State _____ Zip _____ DOB _____ Gender_____

Email _____ Occupation _____

Emergency Contact: _____ Relationship: _____ Phone: _____

What types of healthcare are you receiving? *(Physician, Chiropractor, Acupuncture, Homeopath, etc.)*

_____

Do you currently have, or recently had, any of the following conditions:
(This information is confidential and may be important to your therapy.)

- ☐ Diabetes
- ☐ Arthritis
- ☐ Cancer (history)
- ☐ Allergies _____
- ☐ Numbness or Tingling
- ☐ Headaches_____
- ☐ Skin Conditions
- ☐ Autoimmune Disease _____
- ☐ High Blood Pressure
- ☐ Heart Condition
- ☐ Varicose Veins

Please note any recent injuries, surgeries, major accidents, or serious illness/conditions:

_____

Please list any medications or supplements you are currently taking for <u>any of the above conditions</u>:

_____

Are you pregnant or trying to become pregnant? ☐ No ☐ Yes: Due Date _____

<u>Clients are asked to keep the clinic informed on any changes to the above information</u>.

Previous massage/bodywork experience ☐ Never ☐ Occasionally ☐ Often ☐ Type(s) _____

I understand that: Massage therapy (Which include styles of: Swedish, Sports, Deep Tissue or Deep Massage) involves neither diagnosis nor treatment of any condition and is not a substitute for medical care. Draping will be used at all times. This is a full-body massage unless otherwise requested. <u>Neither breasts nor genitalia will be massaged.</u> I may itemize here any areas on my body that <u>I wish to be avoided,</u> and these will be totally avoided (itemize here if relevant):

_____

<u>If I am uncomfortable for any reason I may request to end the session and it will end promptly</u>.

If client is under the age of 17, written consent from client's guardian or parent is required.

I affirm that I am able to receive Massage Therapy and that any of the information I have provided above does not prohibit me from doing so. I am aware that if I have a medical diagnosis that prohibits me from receiving Massage I must provide physicians written consent prior to services.

Client Signature: _____ Therapist Signature: _____