SOMA THERAPEUTIC MASSAGE
CLIENT INTAKE FORM

NAME:_____ EMAIL:_____

CELL PHONE:_____ HOME PHONE: _____

ADDRESS: _____

OCCUPATION:_____ BIRTHDATE:_____

PRIMARY REASON FOR APPOINTMENT: _____

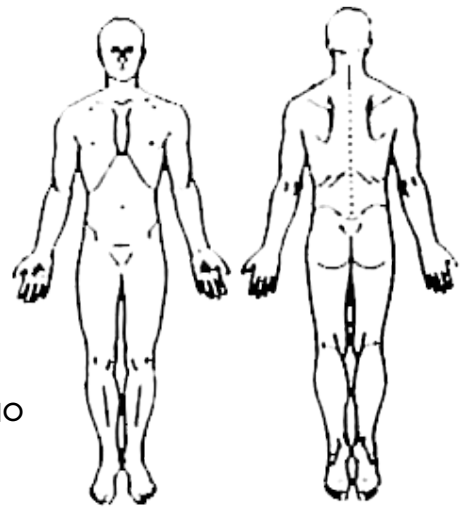
How did you hear about us? / Referral by:_____

Have you ever had a professional massage before? YES / NO
Do you have arthritis? YES / NO
Do you have any varicose veins, blood clots, heart, circulatory or blood pressure problems? YES / NO
Are you taking any heart medications, including blood thinner or blood pressure medications? YES / NO
Do you have any spinal problems? YES / NO
Are you experiencing more stress than usual? YES / NO
Have you suffered any accidents, injuries or surgeries recently? YES / NO
Are you currently under a Doctor's care? YES / NO
Prescription medications that would affect massage (Reason for the medication)

_____

_____

Please mark the figures for any areas of pain, tenderness, numbness or tightness



Do you have any physical conditions, pain or disease that the therapist should be aware of? YES/ NO

If YES, please list:

_____

Are there any areas of the body that you would like the massage therapist to spend more time on YES/ NO

If YES, please list: _____

Are there any areas of the body the massage therapist should avoid due to medical or personal reasons?

YES/ NO. If YES, please list:_____

MASSAGE PRESSURE PREFERENCE

(please circle pressure expectation below)

Therapeutic Services *(Swedish, Reiki, Oncology, Prenatal, Myofascial Release, Lymphatic Drainage & Seattle Method)*

Soft/Relaxation Medium — Medium/Firm

Deep Therapeutic Services *(Deep Tissue, Reflexology & Sport)*

Medium Deep/Deep

Consent for Treatment

I understand that the massage therapy given here is for the purpose of stress and pain reduction, relief from muscular tension or spasm, and for increasing circulation and energy flow. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment or pharmaceutical or perform spinal manipulations. I understand that massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see an appropriate health care provider for any physical aliment that I might have. With this in mind, I agree to receive massage therapy and hold harmless SOMA Therapeutic Massage and the massage for any problems that might arise as a result of the massage session.

I also consent to providing a credit card to schedule future appointments.Your credit card will not be charged at this time. Your credit card is used as a guarantee to reserve your appointment. A 6 hour advance notice is required when canceling a massage appointment. With cancellations of 6 hours or less, 100% of the scheduled service price will be charged to this credit card as a cancellation fee.

Client Signature: _____ Date: _____

Parent or Guardian Signature(In case of a minor):_____ Date: _____