Metta Massage & Energy Therapy, LLC

Client Intake & Health History Form

Name:____ Date:________________

Address:____

City, State, Zip:____ Date of Birth:____________________

Phone:________________ ☐Home ☐Cell ☐Work Phone:_________________ ☐Home ☐Cell ☐Work

Occupation & Employer:____________________________ Email address:___________________________

In case of emergency, please notify:_______________________________ Phone:______________________

Allergies/chemical sensitivities:____

Any events influencing your well-being at this time?____

When was your last massage? What did you appreciate the most? What did you like least?_________________

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How do you prefer to receive reminders about your appointments (please circle)? Text Email

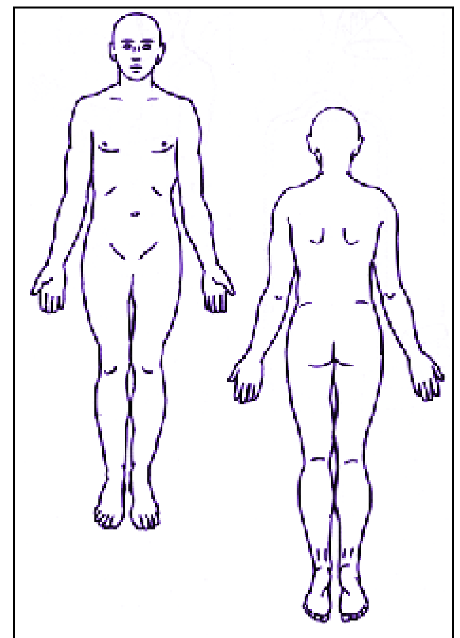
- ☐ Headaches
- ☐ Joint stiffness/swelling
- ☐ Muscle spasms/cramps
- ☐ Broken Bones
- ☐ Strains/sprains
- ☐ Jaw pain/TMD
- ☐ Tendinitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cold sweats
- ☐ Varicose veins/blood clots
- ☐ Stroke
- ☐ Heart condition
- ☐ Asthma
- ☐ Sinus problems
- ☐ High blood pressure
- ☐ Low blood pressure

- ☐ Lymphedema
- ☐ Rashes
- ☐ Allergies
- ☐ Nervous stomach/indigestion
- ☐ Constipation
- ☐ Diarrhea
- ☐ Sleep disorders
- ☐ Cerebral palsy
- ☐ Multiple sclerosis
- ☐ Parkinson's
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Chronic fatigue syndrome
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Cancer: Current Past

- ☐ Pregnancy: Current Past
- ☐ Menopause
- ☐ Endometriosis
- ☐ Hysterectomy

- ☐ Fertility concerns
- ☐ Prostate problems
- ☐ Depression
- ☐ Hearing impaired/wearing hearing aids

Circle any areas of pain:



Signature:____ Date: ____________________

Metta Massage & Energy Therapy, LLC

Please be advised of the policies for this office. Your signature below signifies acceptance of these policies.

Cupping Waiver

I have received information on the Massage Cupping Bodywork technique. I understand the effects and after-care recommendations of this treatment. It has been explained to me that there is the possibility of a skin discoloration, or "cup mark," appearing as tissue is released. I am aware that a "cup mark" is not a bruise and that it will dissipate between a few hours and several days.
I agree to notify my therapist of any lesions on my skin, any bulging discs or other spinal problems, any diagnosis of high or low blood pressure, and/or any other conditions that may be contraindications for massage cupping bodywork. This includes disclosing conditions during subsequent sessions that I may have since been diagnosed with by a healthcare professional.
I agree to communicate with my therapist about any benefits of Massage Cupping Bodywork, and any issues I may have with the treatment. I understand that this session is for my benefit and treatment and I am allowed and encouraged to give input into what takes place.

Please Initial Here ____________________________________

Cancellation Policy & Late Arrivals

We request 24-hour notice for the cancellation of appointments or full payment is required. Same-day cancellations will be charged the full session fee. Clients will be charged full payment for missed or forgotten appointments. Massage appointments are booked closely together so there may not be enough time for a full session if you arrive late to an appointment. Late arrivals will be charged the full session fee.

Payment

Acceptable forms of payment include cash, personal checks, or credit cards (Visa, MasterCard, Discover, American Express). There will be an additional $25.00 charge for returned checks.

Sickness

Massage/bodywork is not appropriate care for infectious or contagious illness. Please cancel your appointment as soon as you are aware of an infectious or contagious condition. If it is within the 24-hour notice period, the cancellation fee may be waived.

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.
I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.
Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.
I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.
Understanding all of this, I give my consent to receive care.

Signature:____ Date:________________