

DEBORAH P WILSON, LMT
CLIENT INTAKE FORM

Client's Full Name _____ Date _____

Street _____ City _____ State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Referred by _____

Emergency Contact _____ Phone _____

Occupation _____ Female Male DOB _____

Yes No Have you ever experienced a professional massage or bodywork session? How recently? _____

Please read carefully the following information and sign where indicated. If you have specific medical conditions or symptoms, massage therapy may be contraindicated. A referral from your physician may be required prior to service being provided.

Are you currently suffering from any ailment which could be affected by today's massage? If yes, explain.

If yes, are you currently under a doctor's supervision for this ailment? _____

Physician _____ Health Insurance Carrier _____

If you answer "yes" to any of the following questions, please explain as clearly as possible.

- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you frequently suffer from stress? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you bruise easily? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had any broken bones in the past two years? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience frequent headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you been in an accident or suffered any injuries in the past two years? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have tension or soreness in a specific area? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from arthritis? | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing contact lenses? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have cardiac or circulatory problems? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing dentures? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from back pain? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have numbness or stabbing pains anywhere? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" to previous question, are you taking medication for this? | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you very sensitive to touch or pressure in any area? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from epilepsy or seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? Explain below. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from joint swelling? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any other medical condition, or are you taking any medications I should know about? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have varicose veins? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any contagious diseases? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have osteoporosis? | Comments _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any allergies? | |

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 understand that massage 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 therapists 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 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.

_____	_____
Client signature	Date
_____	_____
Practitioner signature	Date

DEBORAH P WILSON, LMT
INFORMED CONSENT AGREEMENT

I, _____, understand that TK, transformational kinesiology, a modality facilitated by Deborah P Wilson, is for the purposes of relaxation, stress reduction, clarifying and energizing goals, energy balancing, releasing blockages and limiting beliefs. I understand that the massage therapy given to me by is for the purposes of relaxation, stress reduction, pain reduction, relief from muscle tension and increasing circulation.

I understand that TK and massage therapy do not diagnose illness or disease, or any other disorder, and that Deborah Wilson, licensed massage therapist and certified TK practitioner, does not prescribe medical treatment or pharmaceuticals.

I understand that TK and massage therapy are not a substitute for medical examinations, medical care, or mental health care, and that it is recommended that I am concurrently working with my primary caregiver for any condition I may have.

I have stated all my known physical conditions, medical conditions, and medications, and I will keep the massage therapist updated on any changes. I agree to advise Deborah Wilson should I feel any discomfort or pain, physically or emotionally, so that she may take appropriate steps to address discomfort and pain.

_____ Client signature	_____ Date
_____ Practitioner signature	_____ Date

Consent to Treatment of Minor:

By my signature below, I hereby authorize _____ to administer massage, bodywork or transformational kinesiology to my child or dependent, _____, as they deem necessary.

_____ Parent or Guardian signature	_____ Date
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