Transformation Massage Therapy, LLC

8850 Ralston Rd. Suite 205 Arvada, CO 80002

(303) 422-5500

Client Intake

Please Print	
Name	Date
Address- Street, City, State, & Zip: _____ _____	Please Include Area Code Home Phone: _____ Cell Phone: _____ Work Phone: _____
E-Mail Address (Optional) _____ Would you like to receive an appointment reminder by email? ☐ Yes ☐ No, thank you Would you like to receive our newsletter (4 yearly) and special offers by email? ☐ Yes ☐ No, thank you	At which phone number would you like to receive appointment reminder calls? ☐ Home ☐ Cell ☐ Work ☐ None, thank you
Occupation/Basic Job Description _____	Emergency Contact:_____ Relationship to you:_____ Phone:_____
Birth Date:_____ Age:_____ Sex: ☐ Male ☐ Female	Have you received massage before? Briefly explain your experience. _____ _____ _____
Primary Medical Practitioner & Phone Number: _____ _____	
Consent to Treat Minor (signed by parent or guardian) _____	How did you hear about us? _____

We Love Referrals! If you enjoy your massage please tell others about us. We in turn will give you $10 off your next massage every time your name shows up in the above box.

Thank you!

Health History

Main reason for seeking massage_____

Please list all medications and purpose & nutritional supplements_____

_____

_____

Please list any allergies_____

Please list any auto accidents, surgeries, falls or other traumatic events which may still be a factor for your health

_____

_____

Please list any areas that will be sensitive to touch_____

Please mark any that apply:

○ Angina	○ Whiplash	○ HIV Positive	○ Rheumatoid Arthritis
○ Stroke	○ Neck Pain	○ Osteoporosis	○ Displacement of Ribs
○ Herpes	○ Headaches	○ Osteoarthritis	○ Pain Down Leg/Sciatica
○ Asthma	○ Dislocations	○ Varicose Veins	○ Hardening of the Arteries
○ Sprains	○ Constipation	○ Low Back Pain	○ Jaw Pain/ TMJ Dysfunction
○ Cancer	○ Hospitalization	○ Skin Conditions	○ Numbness/Tingling in Limbs
○ Bruising	○ Abdominal Pain	○ Medical Implants	○ Pregnancy (in the last year)
○ Epilepsy	○ Menstrual Pain	○ Thrombophlebitis	○ High ○ Low Blood Pressure
○ Fractures	○ Plantar Fasciitis	○ Fatigue/Low Energy	○ History of Abuse/Other Trauma
○ Diabetes	○ Cold Extremities	○ Recurrent Infection	○ Hepatitis A B C (circle one)

Of the above marked circles, please explain any that are relevant to your current situation/needs:

_____

_____

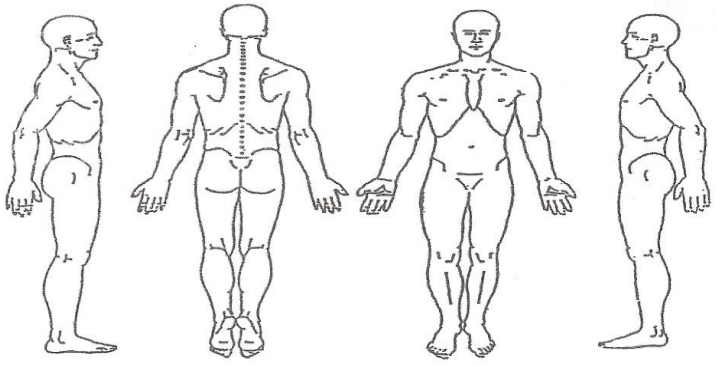
_____

What else do we need to know to be most beneficial for you?_____

_____

Please mark the areas of concern on the diagram to the right.

Please describe the length and type of discomfort for areas indicated (ex: sharp, dull, achy, numbness, shooting or tingling)



I understand that the above information is confidential and will be handled as a medical record by the staff of Transformation Massage Therapy.

Signed_____ Date_____

Client Rights and Responsibilities

You have the Right to:

- **Appropriate touch:**
  - Non-sexual touch
  - Appropriate depth of pressure
  - Informed consent for area to be massaged (ex: the therapist may ask if you would like to receive massage to your abdominal area)
- Report unethical behavior
- End a session at any time
- Discuss your treatment with any one you choose including another massage professional
- Confidentiality, for both your session and any personal information you provide

You have the Responsibility to tell your therapist if the depth of pressure is not fitting your needs. If the pressure is too deep your muscles will tighten to protect themselves which is not beneficial to your body; if the pressure is too light, you may not receive the full benefit of the body work. If you are not enjoying the style of massage please let your therapist know, your therapist is trained for different styles of massage and can change her approach to suit your needs.

You have the Responsibility to report medical conditions as well as prescription drugs to your therapist as this may affect the approach your therapist needs to take with the massage.

Please remember that your massage therapist is not a doctor or counselor, and any suggestions made during your visit are recommendations only, not prescriptions.

Being under the influence of alcohol or drugs that alter perception can put you at risk during massage, therefore Transformation Massage Therapy reserves the right to refuse service.

Sexual advances toward massage therapists are grounds for immediate refusal of service.

I understand the above statement, Signed_____ Date_____

No-show/Late Cancellation Policy

Please be courteous to your massage therapist by giving 24 hours notice to cancel an appointment. If you are unable to do so please give as much notice as possible. If less than three hours notice is given, or there is no cancellation call there will be a charge of $25 per occurrence. Exceptions may be given for first time occurrence or for emergency circumstances.

Your time is equally valuable to us, if we are not able to give you the same courtesy, of giving at least three hours notice that we will not be able to keep your scheduled appointment, Transformation Massage Therapy will give a $35 credit toward your next massage.

Client Signature_____ Therapist Signature_____