

COPPER RAIN MASSAGE



Client Intake Form

Personal Information

Name _____

Phone (Cell) _____ Email _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

Referred by _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

1. Have you had a professional massage before? Yes No
If yes, how often do you receive massage therapy? _____
2. Do you have any difficulty lying on your front, back, or side? Yes No
If yes, please explain: _____
3. Do you have any allergies to oils, lotions, or scents? Yes No
If yes, please explain: _____
4. Is there any area where you are experiencing tension, stiffness, pain or other discomfort?
 Yes No If yes, please identify: _____
5. What are your expectations for this visit?
 Relaxation Pain Relief Sports prep/recovery Other _____
6. What kind of pressure do you prefer? Light Medium Firm

Medical History

In order to plan a massage session that is safe and effective, some general information about your medical history is important.

7. Are you currently under medical supervision? Yes No
If yes, please explain _____
8. Do you see a chiropractor? Yes No If yes, how often? _____
9. Are you currently taking any medication? Yes No
If yes, please list: _____

Please check the box if you have any of the following:

- | | | | |
|--|--|-----------------------------------|--|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Bruises | <input type="checkbox"/> Pinched Nerve |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Herniated Disks | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cardiac or Circulatory Problems |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Cancer | <input type="checkbox"/> Joint Replacements |

- =====
- | | |
|---|---|
| <input type="checkbox"/> Numbness or stabbing pains | <input type="checkbox"/> Suffer from epilepsy or seizures |
| <input type="checkbox"/> Suffer from joint swelling | <input type="checkbox"/> Body piercings(other than ears or face) |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Sensitive to touch or pressure in any area |
- =====

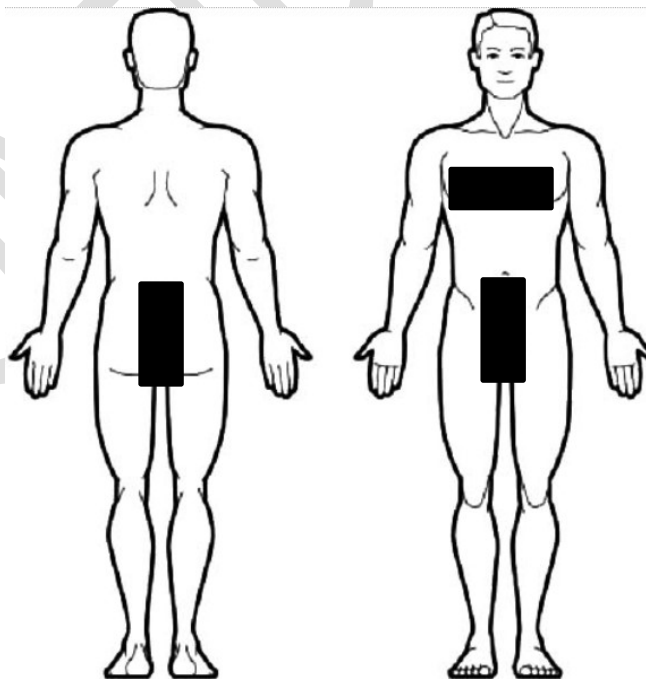
- | | |
|--|---|
| <input type="checkbox"/> Any contagious diseases | <input type="checkbox"/> History of surgeries |
| <input type="checkbox"/> Recent Car Accident | <input type="checkbox"/> Broken bones within two years |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pregnancy -- How many weeks? _____ |
| <input type="checkbox"/> High blood pressure -- Taking medications for it? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please provide additional details for any boxes checked above or other medical conditions:

The shaded areas below are always avoided during the massage

Please place an **X** on any other areas you wish to be avoided

Please **CIRCLE** any specific areas you would like the massage therapist to spend additional time on during the session (Please Note: Abdominal massage is only performed when requested.)



Are you comfortable with the following areas being massaged?

Please circle below.

GLUTEAL / HIP AREA

Yes No

FACE

Yes No

SCALP

Yes No

FEET

Yes No

The Texas Administrative Code, Title 25, Part 1, Chapter 140, Subchapter H, Rule §140.304 states that this initial consultation document is required and that it must include the following information:

Type of massage techniques to be used:



I use a variety of techniques throughout my massages, based on what I find is going on in the tissue. These include Swedish, deep tissue, trigger point, sports, pre-natal, massage for relaxation and relief of muscle pain.

Copper Rain does not perform any massage without proper draping.



“Draping” means that your body will be modestly covered by a sheet during the massage; only the area being worked on will be uncovered.

Copper Rain does not perform breast massage

If the client is uncomfortable for any reason, the client may ask the therapist to cease the massage, and the therapist will do so.



As therapist, I also reserve the right to terminate the session in the event of any sort of abusive behavior from the client. If client misbehavior should result in an abbreviated session, the client will be expected to render full payment.

The parts of the client’s body that will be massaged or the areas of the client’s body that will be avoided during the session.



A typical full-body session will include work on your back, arms, legs, glutes, feet, hands, head, neck, face and shoulders. If desired, the client can request any of these areas to be avoided. This can be noted on this form as well as discussed during the initial consultation.

Informed written consent must be provided by parent or legal guardian for any client under the age 17.

I, the undersigned understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension and should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. If I experience any pain or discomfort during this massage session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. 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 understand that there shall be no liability on the therapist’s part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the License Massage Therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is not advised.

Signature of client _____ **Date** _____

Signature of Massage Therapist _____ **Date** _____