ELEMENTS MASSAGE™ INTAKE FORM

elements massage®

ABOUT YOU

Name			
Email			
Address	City	State	Zip
Your occupation		Date of birth	
How did you hear about us?			

CONTACT INFO

Mobile Phone	Home Phone	Work Phone
☐ OK to leave a message at the number above	☐ OK to leave a message at the number above	☐ OK to leave a message at the number above
Emergency contact name & telephone number		
How you like to be notified of your appointments? Circle all that apply	Telephone Email Text Message (list carrier) _____	

HEALTH HISTORY *(Please check all that apply)*

☐ headaches	☐ seizures	☐ fibromyalgia	☐ wear contact lenses
☐ neck pain	☐ bruise easily	☐ varicose veins	☐ jaw clenching/teeth grinding
☐ back pain	☐ high blood pressure	☐ active cancer (ask for an Oncology Intake form)	☐ numbness/tingling, if so, where _____
☐ leg & knee pain	☐ diabetes		

Please list any conditions or side effects you have and/or medications you are taking associated with these conditions

Accidents, injuries and/or surgeries in the last two years? Please list, include date of occurrence

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No If yes, how many weeks:_____Due date:_____	Postpartum two years or less? ☐ Yes ☐ No If yes, birth date:_____

Do you have any allergies and/or skin sensitivities?
☐ Yes ☐ No If yes, please list:

Our lotion products may contain nut oils. Are you allergic to nuts or nut products?
☐ Yes ☐ No If yes, please list the types of nuts:

Are there any additional medical issues we should know about?
If you have an issue you do not wish to state on this form, please discuss it with your therapist.

Do you have a Section 125 Health Savings Account (HSA), Flexible Spending Account (FSA), or Health Reimbursement Account (HRA)? ☐ Yes ☐ No

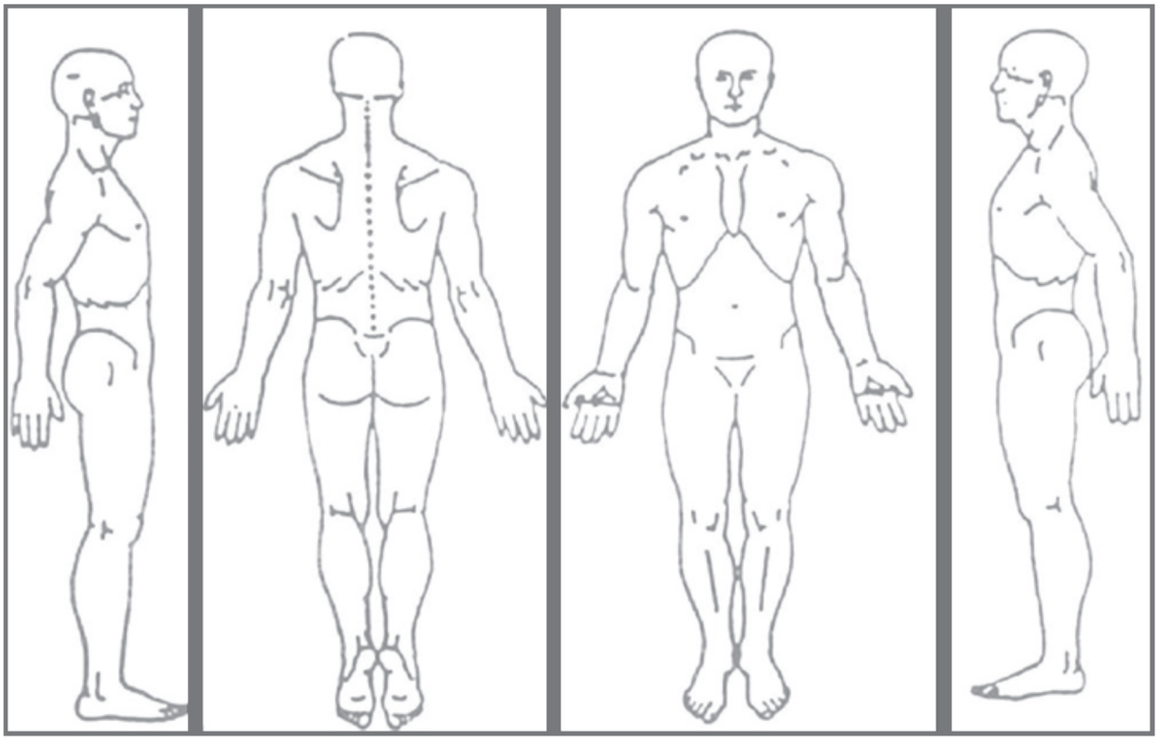
TERMS & CONDITIONS

LEGAL INFORMATION: BY SIGNING BELOW, I AGREE THAT I HAVE READ AND UNDERSTAND THE FOLLOWING - I understand that massage is not a replacement for medical care and that no medical diagnosis will be made. Because massage and bodywork therapy may be contraindicated due to certain medical conditions, I affirm that I have informed the therapist of all known medical conditions and will keep the therapist updated as to any changes in my medical condition going forward. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or manipulations, draping or environment may be adjusted to my level of comfort.
CLIENT BEHAVIOR - Any illicit or sexually suggestive comments or actions made by me will result in immediate termination of the session and I am responsible for full payment.
NON-SOLICITATION POLICY - I will not solicit, recruit or encourage any person employed by this Elements Massage™ studio for employment or the provision of services outside of the studio.
24 HOUR CANCELATION POLICY - Should I cancel or miss an appointment with less than 24 hours notice, I authorize this Elements Massage™ to charge my VISA/MC/Amex/Discover or checking account for the full session fee.
EMAIL POLICY - We will use your email address for appointment reminders, promotions and news from Elements Massage™. Your privacy is important to us. We will not sell, rent or give your name or address to anyone. To unsubscribe or to receive less or more information, you can select a link at the bottom of every email.
CLIENT INFO - If this Elements Massage™ studio accepts insurance or is located in a mandatory PIP (personal injury protection) state, it is required to comply with HIPAA. Otherwise, this Elements Massage™ studio is NOT required to comply with HIPAA, but does treat client information as private and complies with applicable laws that protect the privacy and security of clients' personal data.

Signature	I acknowledge that I have received notice of (or have been given the opportunity to review) HIPAA privacy practices (if applicable) or this Elements Massage™ studio's privacy and security policy._____ (initial here)	Date	Therapist Initials

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:

A statement of the type of massage techniques to be used:	LMT must circle applicable techniques: Swedish, deep tissue, trigger point, sports, and/or Esalen style massage, for relaxation and relief of muscle pain and/or lymphatic drainage therapy for relief of minor edema, swelling and water retention.
The massage therapist will not perform breast massage on female clients without the written consent of the client (Elements does not perform breast massage).	For lymphatic drainage of sore or swollen breast tissue. If applicable, please discuss with me and sign here: I consent: _____
Draping will be used during the session, unless otherwise agreed to by both client and therapist (at Elements we do not perform any massage without proper draping).	"Draping" means that your body will be modestly covered by a sheet during the massage. If you do not wish to be covered by a sheet, please discuss with me and sign here. I consent: _____
A statement that 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 a 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, including indications and contraindications.	To be completed by LMT. In the chart below, please: • Place an X on any areas to be avoided. • Place a CIRCLE on areas that need extra attention. • Place a "T" where the client indicates they are ticklish.



I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications and that spinal manipulations are not part of massage therapy. I understand that massage therapy is not a substitute for medical treatment or medications and that it is recommended that I concurrently work with my Primary Caregiver for any conditions that I may have.

Client Signature:	Date:
LMT Signature: License#	Date: