TIFFANY DILL
MASSAGE THERAPIST

Client Intake & Health History Form

Please complete this form prior to your first appointment. All information is kept confidential and used only to provide safe and effective massage therapy.

CLIENT INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Cell Phone: _____

Address: _____City: _____ State: _____ Zip: _____

Email: _____

Occupation: _____

Emergency Contact

Name: _____Relationship: _____ Phone:_____

HEALTH HISTORY

Are you currently under the care of a physician? □ Yes □ No

Please list any health conditions, medications, recent injuries or surgeries, and areas of pain or discomfort that may affect your massage.

Please check any conditions that apply to you:

□ High Blood Pressure
□ Low Blood Pressure
□ Heart Disease
□ Diabetes
□ Arthritis
□ Osteoporosis
□ Cancer
□ Fibromyalgia

□ Chronic Pain
□ Headaches/Migraines
□ Sciatica
□ Neuropathy
□ Blood Clots
□ Varicose Veins
□ Recent Surgery
□ Recent Injury

□ Joint Replacement
□ Neck Pain
□ Back Pain
□ Pregnancy
□ Skin Conditions
□ Allergies
□ Anxiety
□ Depression
□ Taking Blood Thinners

□ Other: _____

Pressure Preference: □ Light □ Medium □ Firm

Informed Consent & Client Agreement

Please read each statement carefully and initial each item.

PAYMENT, CANCELLATION & APPOINTMENT POLICY

____ Your appointment time is reserved exclusively for you. Please provide at least 24 hours' notice if you need to cancel or reschedule. Clients arriving late may receive a shortened session to avoid delaying other appointments; however, the full scheduled session fee will still apply.

____ Payment is due in full at the time services are rendered. Appointments canceled with less than 24 hours' notice, missed appointments (no-shows), or appointments terminated due to client misconduct may be charged the full scheduled session fee. Future appointments may require prepayment.

____ I understand that massage therapy is intended to promote relaxation, improve circulation, reduce muscular tension, and support general wellness. Massage therapy is not a substitute for medical diagnosis or treatment.

____ I understand that Tiffany Dill does not diagnose illness or injury, prescribe medications, perform chiropractic adjustments, or treat medical conditions.

____ I understand that massage therapy may involve certain risks, including temporary soreness, tenderness, bruising, or aggravation of existing conditions. No guarantees have been made regarding the outcome of my treatment.

____ I have accurately disclosed my known medical conditions, medications, allergies, injuries, surgeries, pregnancy status, and any other information that could affect my massage session.

____ I agree to notify my therapist before every appointment if there are any changes to my health or medications.

____ I understand that massage therapy provided by Tiffany Dill is strictly therapeutic and professional. Any inappropriate language, sexual comments, advances, or behavior will result in the immediate termination of the session. Full payment for the scheduled appointment will still be required, and future appointments may be refused.

____ I understand that massage therapy services are provided in a private residence. I agree to exercise reasonable care while entering, exiting, and using the driveway, walkways, steps, parking area, and treatment space. I accept responsibility for my personal belongings while on the property.

____ I understand that all information I provide will remain confidential except where disclosure is required by law.

____ I voluntarily consent to receive massage therapy from Tiffany Dill.

RELEASE OF LIABILITY

I understand the nature and purpose of massage therapy and voluntarily choose to receive treatment.

I acknowledge that massage therapy is provided according to accepted professional standards. I release Tiffany Dill from liability for ordinary risks associated with massage therapy services provided within those professional standards, except where prohibited by Colorado law or in cases involving negligence or willful misconduct.

CLIENT ACKNOWLEDGEMENT

I certify that I have read, understand, and agree to the terms outlined in this Client Intake and Consent Form including the Payment, Cancellation & Appointment Agreement. I have completed this form to the best of my knowledge. I have had the opportunity to ask questions regarding massage therapy and consent to treatment.

_____

Client's printed name

_____ _____

Client signature Date