TIFFANY DILL
MASSAGE THERAPIST

Client Intake & Health History Form

Please complete this form prior to your first appointment. 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
□ Fever/current contagious illness
□ Chronic Pain
□ Headaches/Migraines
□ Sciatica
□ Neuropathy
□ Blood Clots
□ Varicose Veins
□ Recent Surgery
□ Recent Injury
□ Active Infection
□ Joint Replacement
□ Neck Pain
□ Back Pain
□ Pregnancy
□ Skin Conditions
□ Allergies
□ Anxiety
□ Depression
□ Taking Blood Thinners

□ Any sensitivities to oils, lotions, fragrances _____
□ Other: _____

Pressure Preference: □ Light □ Medium □ Firm

Informed Consent & Client Agreement

Please read each statement carefully and initial each item.

PAYMENT, CANCELLATION & APPOINTMENT POLICY

I understand that my appointment time is reserved for me. I agree to give at least 24 hours' notice if I need to cancel. Cancellations with less than 24 hours' notice or no-shows will be charged the full session fee.

If I arrive late, my session may be shortened, but I will still pay the full session fee.

MASSAGE THERAPY SCOPE, INFORMED CONSENT & ASSUMPTION OF RISKT

I understand that massage is for relaxation and relief of muscle tension and is not a medical appointment. I understand that soreness, tenderness, or other temporary discomfort may occur after a massage, and I agree not to hold the massage therapist responsible for these normal effects of massage.

CLIENT RIGHTS, PROFESSIONAL CONDUCT & SESSION SAFETY

I understand that I am receiving voluntary services at a private residence and accept responsibility for my safety, including any falls or injuries that may occur on the driveway, walkways, stairways, entryways, or other areas of the property. I understand that I am responsible for using my own insurance in such an event.

MASSAGE THERAPY RELEASE OF LIABILITY

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

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.

CLIENT ACKNOWLEDGEMENT

_____
Client's printed name

_____ _____
Client signature Date