Lower Bucks
Total Health and
Wellness Center, P.C.

# NEW MASSAGE PATIENT INTAKE FORM

**Name**_____**Date**_____

**Address**_____

**Date of Birth**_____**Phone Number**_____

**Email Address**_____

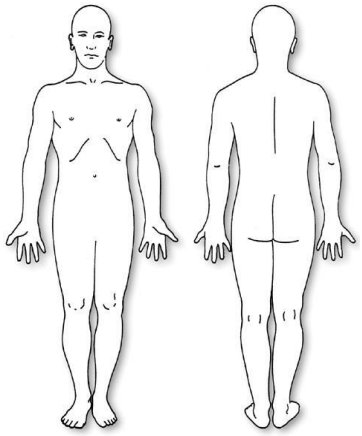
**Emergency Contact**_____**Phone Number**_____

**Referred By (*If Applicable*)**_____

**Is your condition due to a motor vehicle or work related accident? YES / NO**
**If Yes, have you filed a claim with your auto insurance or worker's compensation? YES / NO**

**Attorney's Name (*if applicable*)**_____**Telephone**_____

**Mark an X where you have any pain or other symptoms**



**Please describe when and how your problem began below**

_____

_____

_____

_____

**Are you presently taking any medications?** YES / NO *(If yes, please list them below)*

_____

_____

_____

**Have you had a recent injury or major surgical procedure?** YES / NO *(If yes, please list them below)*

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**Circle any of the following conditions that apply to you, past and present.**
**If needed, please add your comments to clarify the condition.**

| | | |
|---|---|---|
| Headaches | Indigestion | Rashes |
| Joint stiffness / Swelling | Constipation | Scoliosis |
| Spasms / Cramps | Intestinal gas / Bloating | Allergies |
| Broken / Fractured bones | Diarrhea | Athlete's foot |
| Strains / Sprains | Irritable bowel syndrome | Impetigo |
| Back, hip pain | Crohn's Disease | Hemophelia |
| Shoulder, neck, arm, hand pain | Colitis | Tuberculosis |
| Leg, foot pain | Numbness / Tingling | Chest, ribs, abdominal pain |
| Problems walking | Fatigue | Loss of Appetite |
| Jaw pain / TMJ | Sleep disorders | Depression |
| Tendonitis | Ulcers | Difficulty concentrating |
| Bursitis | Paralysis | Hearing Impaired |
| Osteoarthritis | Herpes / Shingles | Visually Impaired |
| Rheumatoid Arthritis | Cerebral Palsy | Diabetes |
| Osteoporosis | Epilepsy | Fibromyalgia |
| Dizziness | Sciatica | Plantar Fasciitis |
| Shortness of breath | Multiple Sclerosis | Cancer |
| Fainting | Muscular Dystrophy | Low blood pressure |
| Cold feet or hands | Parkinson's Disease | High blood pressure |
| Cold sweats | Stroke | Asthma |
| Heart condition | Pregnancy | Other_____ |

I understand that a massage Therapist does not diagnose disease, illness, or prescribe any treatment or drugs, nor do they provide spinal manipulation. I understand that Sonja Lay may end the session for any inappropriate behavior. I have stated all of the conditions that I am aware of, and this information is true and accurate. I will inform Sonja Lay of any changes in my status.

**Client's Signature**_____ **Date**_____

# CONSENT FOR THERAPY AND WAIVER OF LIABILITY

The undersigned client hereby freely consents to receipt of massage services from Sonja Lay

**Client agrees as follows**

Client understands and agrees that they will provide Sonja Lay with complete and accurate health information and a written referral from client's primary healthcare provider if they are currently receiving care or has a specific medical condition or symptoms for which client takes medication or receives periodic evaluations or treatment. Client understands that massage therapy is designed to be an ancillary health aide and is not a suitable form for primary medical treatment for any condition.

1. Client and Sonja Lay have discussed the potential benefits and possible side effects of massage therapy and have agreed upon a course of focused attention and manual therapy for the predetermined goals of stress reduction, relief of muscular discomfort, and/or promotion of general health. Client has been given an opportunity to ask questions of the Therapist and has received all requested information.

2. Client understands that the unclothed body will be draped at all times for warmth, sense of security and as a mark of massage therapy professionalism. Client agrees to immediately inform Sonja Lay of any unusual sensation or discomfort so that the application of pressure may be adjusted to their level of comfort. Client understands that massage therapy is not sexual in any manner and that any illicit or suggestive remarks or behavior on the client's part will result in an immediate termination of the therapy session. Client understands that payment will be expected in full regardless of whether the massage is completed or not.

3. Client hereby assumes full responsibility for receipt of the massage therapy and releases and discharges both Sonja Lay and Lower Bucks Total Health and Wellness Center, P.C. from any and all claims, liabilities, damages, actions or causes of action arising from the therapy received hereunder including, without limitation, any damages arising from acts of active or passive negligence on the part of Sonja Lay to the fullest extent allowed by law.

4. Client, in signing this consent for Therapy and Waiver of Liability ("Consent"), understands and agrees that this Consent will apply to and govern the current and all future therapy sessions performed by Sonja Lay.

_____

**Client's Name (print)**

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**Client's Signature** **Date**

Parent/Guardian **MUST** sign for all clients under 18 years of age

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**Authorized Facility Signature** **Date**