Healing Soles

RESTORE • RENEW • REBALANCE

MASSAGE THERAPY

61 Main Street, Stoneham, MA

508-246-6740

CLIENT INTAKE & CONSENT FORM

CLIENT INFORMATION

FULL NAME: _____

DATE OF BIRTH: _____

PHONE NUMBER: _____

EMAIL ADDRESS: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT

NAME: _____

RELATIONSHIP: _____

PHONE NUMBER: _____

ABOUT YOUR VISIT

HOW DID YOU HEAR ABOUT US? _____

REASON FOR VISIT / WHAT ARE YOU HOPING TO RECEIVE FROM THIS SESSION? _____

_____

HEALTH HISTORY

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU:

- ☐ HIGH BLOOD PRESSURE
- ☐ HEART CONDITION
- ☐ DIABETES
- ☐ CANCER
- ☐ ARTHRITIS / JOINT PAIN
- ☐ OSTEOPOROSIS
- ☐ PREGNANCY (IF YES, HOW MANY WEEKS? _____)
- ☐ RECENT SURGERY (IF YES, WHEN? _____)
- ☐ NEUROPATHY / NERVE PAIN
- ☐ FIBROMYALGIA
- ☐ BLOOD CLOTS / DVT
- ☐ VARICOSE VEINS
- ☐ SKIN CONDITIONS / RASHES
- ☐ MIGRAINES / HEADACHES
- ☐ OTHER: _____

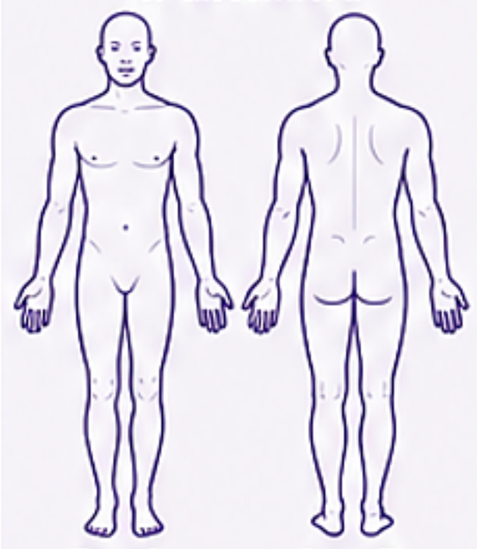
PLEASE LIST ANY MEDICATIONS, ALLERGIES, INJURIES, OR MEDICAL CONDITIONS NOT LISTED ABOVE:

_____

_____

PAIN SCALE

On the diagrams below, please shade the areas where you currently feel pain, tension, or discomfort.



CONTRAINDICATIONS – ASHIATSU MASSAGE

Ashiatsu is a deep, therapeutic massage performed using the therapist's feet. **For your safety, Ashiatsu may NOT** be appropriate if you are currently experiencing any of the following:

- Blood clotting disorders
- Acute injuries or fractures
- Severe osteoporosis
- Pregnancy (first trimester or high risk)
- Uncontrolled high blood pressure
- Recent surgery (within 6 weeks)
- Fever or active infection
- Open wounds or skin infections
- Severe varicose veins
- Certain heart conditions
- Any condition your physician advises against deep pressure

WHEN IN DOUBT, PLEASE CONSULT YOUR PHYSICIAN BEFORE RECEIVING MASSAGE THERAPY.

CANCELLATION POLICY

We kindly ask for at least 24 hours' notice for any cancellations or rescheduling. Late cancellations or no-shows may be subject to a fee.

CONSENT & LIABILITY WAIVER

I understand that massage therapy is not a substitute for medical care. It is recommended that I see a physician for any ailment that I am aware of. I further understand that massage therapy is contraindicated in certain medical conditions and that I should inform my therapist of any medical conditions that I have.

I understand that massage therapy is intended to enhance wellness and relaxation. I understand that results are not guaranteed and that I may experience some soreness following treatment, which is normal.

I hereby release and hold harmless **Healing Soles Massage Therapy**, its owner, and therapist from any and all liability, claims, or damages that may arise from my session, except in cases of proven negligence.

I have read the above information, completed this form truthfully, and agree to the conditions stated.

CLIENT SIGNATURE: _____ **DATE:** _____

THERAPIST SIGNATURE: _____ **DATE:** _____

PRIVACY NOTICE

All client information is kept confidential and will not be shared without your consent except as required by law.

Thank you for choosing Healing Soles. We look forward to helping you restore, renew, and rebalance.