8412 Katy Freeway Suite 330 Houston, TX. 77024
713.647.6453

CLIENT INTAKE FORM

Name ______________________________ Date of Birth ___________
Address _____________________ City _________ State __ Zip Code ___________
Occupation _________________________
E-Mail: _____________________________ Contact# _____________ Contact# _____________

Current Medical Information

Are you currently under a physicians care? Yes __ No __ If yes, please explain ______________________

Are you receiving profession counseling? Yes __ No __ If yes, please explain ______________________

Are you pregnant or trying to conceive? Yes __ No__ If yes pregnant, how many weeks ____________

Please indicate all medication, vitamins, herbal supplements that you are currently taking________________________

Do you wear contact lens? Yes __ No __ Dentures? Yes __ No __ Hearing aid? Yes __ No __

All of this information is confidential, and cannot be shared with anyone by law. Please check all that apply and include any recent rashes, bruises, bumps, fractures, sprain/strains, illnesses, or surgeries. A partial list follows but is not meant to be all – inclusive.

__ Abscess/open sore/surgical site
__ Allergies
__ Arteriosclerosis
__ Asthma
__ Cancer/undiagnosed lump
Type _________________
Diagnosis Date ________
Last Treatment ________
__ Chronic fatigue syndrome
__ Depression
__ Diabetes
__ Digestive Problems
__ Easy Bruising
__ Epilepsy
__ Fibromyalgia
__ Fibrositis
__ Headaches
__ Heart Disease
__ Herniated / Ruptured Disc
__ Herpatitis
__ Herpes I /II
__ History of mental Illness Physical or emotional abuse, Counseling/Therapy
__ HIV / AIDS
__ Hypertension
__ Inner Ear Problems
__ Fluid Retention
__ Implants
Location _______________
__ Lupus
__ PMS/ troublesome cycle
__ Pregnancy (Currently)
__ Osteoarthritis
__ Osteoporosis
__ Phlebitis
__ Rheumatoid Arthritis
__ Skin sensitivity
__ Stomach Ulcers
__ Varicose Veins
__ Insomnia
__ Fractures/ Sprains/Strains
__ Other conditions (include past injuries) that still affect you:

Physicians Information
(This section must be completed if you have conditions such as Diabetes, High Blood Pressure, Lupus, Cancer, HIV / AIDS, etc)

Physician Name ____________________ Phone _____________ City ________________ State _____ Zip ________

Do we have your permission to contact your healthcare provider if needed? Yes ______ No ______

Have you ever experienced massage therapy? Yes __ No ___

What type of massage pressure do you prefer? Featherlight ____ Gentle ____ Firm ____

On a scale of 1 to 10, what is your stress level? _____

Are there any areas of the body that should be avoided? Yes ____ No ____ If yes, please list ____________________

Please indicate anything that you are allergic to: (for aroma therapy purposes) ____________________________
Example: Some aroma therapy oils include peanut oil

Male and female genitalia and women's breast will not be exposed or massaged at any time. In accordance with state laws, my body will be properly draped (covered) at all times, except for the area being worked. If during the session I feel uncomfortable, then I will ask Master Peace Massage / Rosie Williams to end the session. It is my responsibility to inform Master Peace Massage / Rosie Williams of any pre-existing conditions, limitations or specific sensitivities and to inform Master Peace Massage / Rosie Williams if I feel any discomfort during the massage session. If I do experience discomfort, I will inform Master Peace Massage / Rosie Williams to adjust the level of pressure. I understand and voluntarily accept any risks of which I have been advised associated with my massage, and hereby release Master Peace Massage / Rosie Williams from all liability for any injury, including, without limitation, personal, bodily or mental injury, economic loss or any damage to me resulting there from. I further hereby release Master Peace Massage / Rosie Williams from all liability arising from any such injury or damage resulting from my failure to disclose any pre-existing condition, limitation, or specific sensitivities, or my failure to inform Master Peace Massage / Rosie Williams of any discomfort during the session.

The undersigned acknowledges that he/she has read the above document and thereby their signature represents their agreement.

Client Signature: ____ Date: _______ Time: ___________

Therapist Signature: ____ Date: _______ Time: ___________