WANDA H. AKERS
LMBT NC 8323
MASSAGE & RELAXATION

****MASSAGE THERAPY INTAKE FORM****

SERVICE DATE / TIME ____________________

NAME: ____________________ M / F D.O.B. ____________________

ADDRESS: ____________________

HOME PHONE: ____________ CELL: ____________ WORK: ____________

EMAIL ADDRESS: ____________________ OCCUPATION: ____________

HAVE YOU EVER HAD A PROFESSIONAL MASSAGE BEFORE? Y / N

HOW OFTEN DO YOU EXERCISE? ____________ WHAT TYPE? ____________

ANY PROBLEMS SLEEPING? ____________________

ANY ALLERGIES / SENSITIVITIES TO OILS, LOTIONS, SCENTS, OR FOODS? ____________
____

LIST ANY MEDICATIONS YOU HAVE TAKEN TODAY: ____________________
____

HAVE YOU HAD ANY INJURIES / AUTO ACCIDENTS / OR SURGERIES IN THE LAST 2 YEARS?
____

ARE YOU CURRENTLY SEEING A DOCTOR FOR ANY HEALTH ISSUE? ____________
____

ARE YOU DIABETIC? Y / N DO YOU HAVE HIGH BLOOD PRESSURE? Y / N

DO YOU HAVE CARDIAC / CIRCULATORY PROBLEMS? Y / N ____________

DO YOU HAVE VARICOSE VEINS? Y / N DO YOU SUFFER FROM MIGRAINES? Y / N

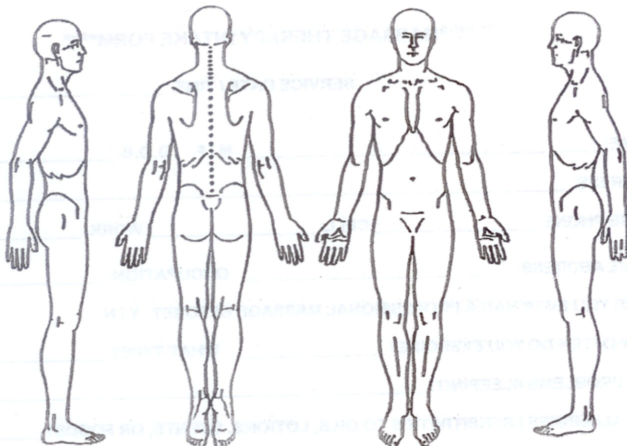
WOULD YOU LIKE FOR ME TO FOCUS ON ANY SPECIFIC AREAS? ____________

ARE THERE ANY AREAS I SHOULD AVOID? ____________________

WHAT KIND OF PRESSURE DO YOU PREFER? LIGHT / MEDIUM / DEEP

IS THERE ANY CHANCE THAT YOU MAY BE PREGNANT? Y / N

USING THE BODY DIAGRAMS BELOW, PLEASE SHADE IN ANY AREA OF DISCOMFORT – IF YOU HAVE ANY NUMBNESS OR TINGLING, USE A SERIES OF X'S TO SHOW THESE AREAS



****MASSAGE THERAPY CONSENT FORM****

I, __________________________, understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation, and is NOT of a sexual nature. Any illicit or sexually suggestive remarks or advances made by me at any point will result in immediate termination of the massage session and removal from the premises. In this case I will be responsible for full payment of the massage. I further understand that the massage therapist does NOT diagnose illness, disease, or any other physical or mental disorder. As such, medical treatment, spinal manipulations, and pharmaceuticals are not prescribed or provided. I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and/or diagnoses, and that it is recommended that I see a physician for any medical conditions. If I am under18 years of age, a parent or guardian must also sign for approval of my massage.

I acknowledge that *Wanda H. Akers, LMBT* **maintains a 24 hour cancellation notice. If I choose to cancel services in less than 24 hours, I may be responsible for the full amount of the service fees, at the discretion of the massage therapist.**

Signature of client ____ **Date** ________________________

Signature of parent ____ **Date** ________________________
(if under age 18)