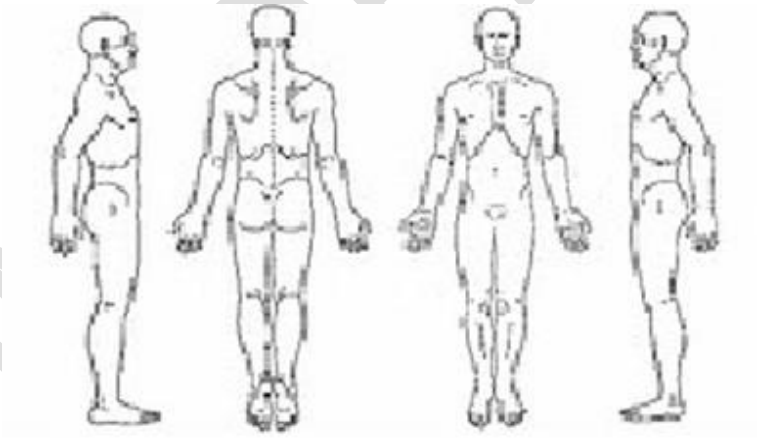
Massage Client Intake Form
Sharon Coen BSc PT, LMT, CAMTC #8365

Personal Information

Last Name _____ First Name _____
Email _____
Phone (Cell) _____
Phone (Home) _____
Address _____
City _____ State _____ Zip _____
Date of Birth _____ Occupation _____
Emergency Contact _____ Phone _____
Relationship to client_____

Please **circle** any particular area of the body where you are experiencing tension, stiffness, pain or other discomfort.



Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

1. Are you currently under medical supervision? Yes □ No □
   If yes, please explain
   _____
2. Please list any current medications that you are taking.
   Aspirin/Anti-inflammatories/steroids_____
   Other _____

3. Please check any conditions listed below that apply to you:

☐ deep vein thrombosis/blood clots/bruising/varicose veins	
recent accident of injury	☐ osteoporosis
☐ surgery	☐ epilepsy
☐ joint replacement	☐ headaches/migraines
☐ sprains/strains	☐ cancer
☐ diabetes	☐ numbness/ tingling
☐ allergies	☐ back/neck pain
☐ cardiac condition	☐ Fibromyalgia/ autoimmune disease
☐ high or low blood pressure	☐ varicose veins
☐ pregnant_____ months	

Please explain any condition that you have marked above _____
_____

4. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?
_____

Print Name _____Signed _____
Date_____

SHARON COEN BSc PT. BCTMB.

LMT#8365

MASSAGE THERAPY CONSENT FOR TREATMENT

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware.

I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive massage therapy.

Client Name: _____Signature _____

Date: _____

Witness: _____ Date: _____

SHARON COEN BSc PT. BCTMB.
LMT#8365

MASSAGE THERAPY CANCELLATION POLICY

If you cannot make your massage appointment for **any** reason, please provide us with *at least* 24 hours notice prior to your appointment time.

If 24 hours notice is not given, you will be charged **100%** of the cost of your scheduled appointment. This fee is payable directly to the massage therapist and must be paid in full before you receive your next massage.

For patients under the age of 18: The parent of the minor whom the massage is scheduled for is responsible for the **100%** cancellation fee.

Please read and sign the following statement:

I have read the above statement and understand that if I do not provide 24 hours notice prior to my appointment, I will be responsible for 100% of the cost of the scheduled massage. I agree and take full responsibility for payment in full before receiving my next massage.

Patient Name: _____

Patient Signature: _____ Date: _____
_____

Witness: _____ Date: _____

THERAPEUTIC MASSAGE

SHARON COEN

(949) 294 6798

Health Information–COVID-19 Prescreen & Liability Waiver Client

Name: _____

COVID-19 Information

1. Have you had a fever in the last 24 hours of 100°F or above? Yes ☐ No ☐
2. Do you now, or have you recently had, any respiratory or flu symptoms, runny nose, sore throat, cough or shortness of breath in the last 14 days? Yes ☐ No ☐
3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes ☐ No ☐ 4. Have you travelled outside of The USA in the last 14 days? Yes ☐ No ☐

Consent for Treatment

I understand that, because massage therapy/bodywork involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless **Sharon Coen, Therapeutic Massage** from any claims related thereto. I give my consent to receive treatment from Sharon Coen.

Client Signature_____ Date: _____

Witness signature: _____Date: _____