Heavenly Hands of Maricopa

Treat yourself to a little slice of Heaven in your own backyard.

Heavenly Hands Massage Intake Form

Name			Date
Street	City	St.	Zip
Date of Birth	Email	Cell Number	

Emergency Contact

Name	Relationship	Phone Number

Are you presently taking any medication? ❑ Yes ❑ No

If Yes Please Explain:

Have you had a recent major surgical procedure or injury? ❑ Yes ❑ No

If Yes Please Explain:

Are you currently seeing a Chiropractor, Physical Therapist, or Physician for an ongoing issue? ❑ Yes ❑ No

If Yes Please Explain:

Do your prefer a Scalp massage? ❑ Yes ❑ No

Is there a specific area of the body where you are experiencing tension, stiffness, pain or discomfort? ❑ Yes ❑ No

If Yes Please Explain:

_____

_____

_____

Do you have any allergies? ❑ Yes ❑ No

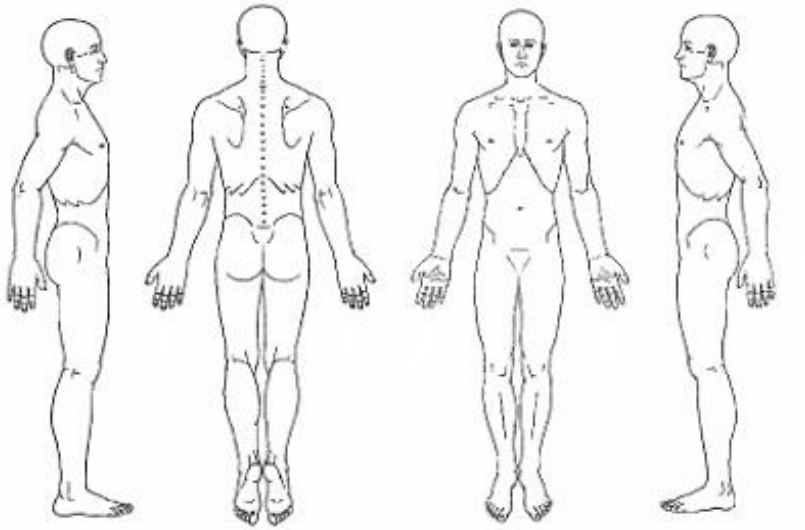
If Yes Please Explain:

How did you hear about me?

Intake Form

Please check the following conditions that apply to you, past and present.
Please add any comments to clarify the condition.

- ❑ Abdominal Pain
- ❑ Allergies
- ❑ Arthritis
- ❑ Blood Clots
- ❑ Carpal Tunnel
- ❑ Chest Pain
- ❑ Circulatory Disorder
- ❑ Constipation
- ❑ Contagious Disease
- ❑ Depression
- ❑ Diabetes
- ❑ Digestive Disorders
- ❑ Dizziness
- ❑ Fatigue
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Insomnia
- ❑ Joint Disorder
- ❑ Kidney Disorder
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Migraine Headache
- ❑ Muscular Injuries
- ❑ Respiratory Disorder
- ❑ Sinusitis
- ❑ Skeletal Injuries
- ❑ Skin Disorder
- ❑ Spinal Disorder
- ❑ Varicose Veins
- ❑ Other: _____



Please shade in or mark an X on the areas that are causing you discomfort and/or pain.

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 that I am aware of. I understand that massage therapists are not qualified to perform 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 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

_____ _____

Client's Signature Date

Consent for Therapy and Waiver of Liability

The undersigned ("Client") hereby freely consents to receipt of massage services from:

Tamara Buchanan

Licensed Massage Therapist Name

Client agrees as follows:

Client understands and agrees that they will provide the Therapist with complete and accurate health information and a written referral from Client's primary healthcare provider if Client is 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 aid and is not suitable for primary medical treatment for any condition.

1. Client and Therapist have discussed the potential benefits and possible side effects of massage therapy and have agreed upon a course of focused attention and 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 the Therapist of any unusual sensation or discomfort so that the application of pressure may be adjusted to Client's 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 if the massage is completed or not.
3. Client hereby assumes full responsibility for receipt of the massage therapy, and releases and discharges Therapist 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 the Therapist, 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 Therapist.

_____	_____	_____
Client (**printed name**)	Client (**signature**)	Date
_____	_____	_____
Massage Therapist (**printed name**)	Massage Therapist (**signature**)	Date