



10154 Jefferson Hwy.

Baton Rouge, LA 70809

225-456-7577

**Confidential Client Intake Form**

Name: \_\_\_\_\_ Nick Name: \_\_\_\_\_
e-mail: \_\_\_\_\_ DOB: \_\_\_\_\_
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Other: \_\_\_\_\_
Mailing Address: \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
Age: \_\_\_\_\_ Marital Status S M D W How Many Children? \_\_\_\_\_
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_
Referred By: \_\_\_\_\_
Primary Care Physician: \_\_\_\_\_

**History and Health Information**

Do you suffer from: (please circle all that apply)

- Acne Dermatitis HIV/AIDS Respiratory Disorder
Anemia Dizziness Hyperglycemia Rheumatoid Arthritis
Arthritis Diabetes Hypotension Rosacea
Asthma Digestive Disorders Kidney Dysfunction Shingles
Allergies DVT Liver Disorder Sciatica
Backaches Eczema Nerve Damage Sinus Trouble
Cancer Edema/Swelling Osteoarthritis Stroke
Carpal Tunnel Fibromyalgia Osteoporosis Tendinitis
Celiac Disorder Flu/Cold/Fever Phlebitis TMJ syndrome
Cramps Gout Plantar Fasciitis Tuberculosis
Chronic Inflammation Headache PMS Thyroid Disorder
CFS/MPS Heart Trouble/Disease Pregnant Varicose Veins
Depression High Blood Pressure Psoriasis
Compromised Immune System Congestive heart failure

Purpose for a massage today \_\_\_\_\_
Doctors seen for this/these condition(s) \_\_\_\_\_
Have you been treated for any other health condition by a physician in the last year? \_\_\_\_\_
Describe \_\_\_\_\_
Medications \_\_\_\_\_
Remarks and Additional Information \_\_\_\_\_
Have you received therapeutic massage before? YES / NO
Do you have sensitivity to scents or essential oils? YES / NO

Clinic Policies:

- Please present all coupons and gift certificates at the time of appointment.
- We will be happy to accommodate late arrivals, however appointments will end at the scheduled time and full charge will apply.
- \$45.00 will be charged for all appointments canceled or missed without 24 hour prior notice.
- \$35.00 charge for all NSF checks.
- We follow all HIPPA guidelines and will not share or discuss any of your treatment without written consent.
- We accept cash, debit cards, checks, Visa, MasterCard, Discover and American Express.

I understand that if I experience any pain or discomfort during my session, I will immediately inform the therapist. I also understand that massage should not be considered a substitute for medical examination, diagnosis or treatment and I agree to seek qualified medical care for any mental or physical illness that I am experiencing. I recognize that massage therapists, though certified, are not licensed health care professionals and are not qualified to diagnose, treat or prescribe for illness or injury and I will request a referral if such is required. I also understand that certain contraindications exist for massage therapy and I will inform my massage therapist immediately if any changes to my health profile occur. I agree that my massage therapist will not be held liable for any negative effects if I fail to update my profile or provide complete information. Finally, I understand that any illicit or sexually suggestive remarks or advances will not be tolerated and will result in the immediate termination of the session with full payment due.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature (required if client is under 18): \_\_\_\_\_