



# Ouroboros Massage

## Client Intake Form

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Street Address: \_\_\_\_\_

DOB: \_\_\_\_\_

Apt. #: \_\_\_\_\_

Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

Text Appt. Reminders? Y N

Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

How did you hear about Ouroboros Massage?: \_\_\_\_\_

Have you ever received a professional massage before? Y N

Are you/is there a chance you could be pregnant? Y N If yes, how far along? \_\_\_\_\_

Do you have any allergies or sensitivities to oils, lotions, ointments, gels or scents? Y N

If yes, please explain: \_\_\_\_\_

Are you currently on any medications or taking any supplements? Y N

If yes, please list: \_\_\_\_\_

Please list any major surgeries: \_\_\_\_\_

Please indicate if you currently have or have ever had any of the following:

- Anemia
  - Allergies/Sensitivities
- If yes, please list: \_\_\_\_\_

- Joint Replacement
- If yes, please indicate: \_\_\_\_\_

- Arthritis/Tendonitis
- Autoimmune Disease
- Blood Clots
- Bruise Easily
- Cancer
- Congestive Heart Failure
- Diabetes
- Difficulty Breathing
- Fibromyalgia
- Headaches/Migraines
- Heart/Circulation Problems
- Hemophilia
- High/Low Blood Pressure
- HIV/AIDS
- Joint Dysplasia

- Multiple Sclerosis
- Osteoporosis/Osteoarthritis
- Pinched Nerve(s)
- Sciatica
- Scoliosis
- Seizures
- Sensitive Skin
- Skin Condition(s)
- Sprain/Strain
- Thrombophlebitis/Deep Vein Thrombosis
- TMJ Dysfunction
- Varicose Veins
- Conditions not listed that you would like your therapist to know about:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

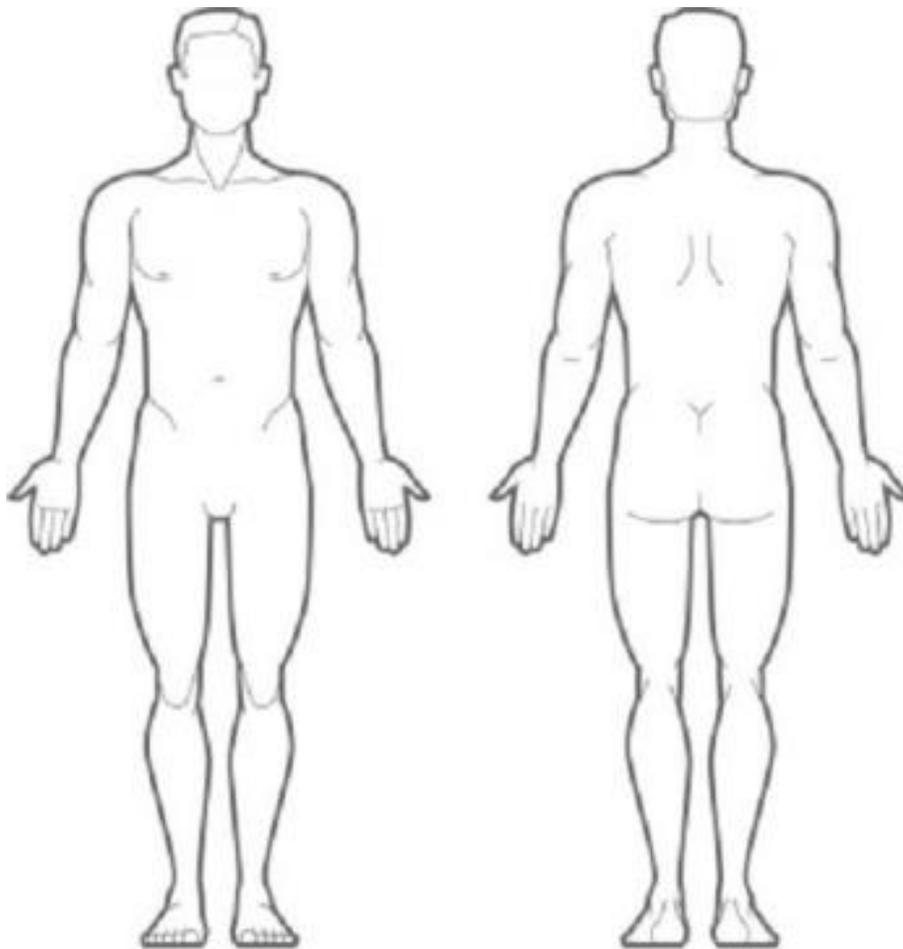
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What is the reason for your visit today? \_\_\_\_\_  
\_\_\_\_\_

What are your major complaints, concerns or areas to be worked? \_\_\_\_\_  
\_\_\_\_\_

What are you looking to get out of your session today? (ex. relaxation, pain relief, stress relief, etc.) \_\_\_\_\_

Please indicate below where you are experiencing pain and/or discomfort with an "X". Mark any areas of radiating pain by circling and include all affected areas.



Are you currently or have you experienced any of the following within the past 7-14 days:

- |   |   |
|---|---|
| <input type="checkbox"/> Flu or flu-like symptoms     | <input type="checkbox"/> Respiratory distress or chest discomfort |
| <input type="checkbox"/> Fever                        | <input type="checkbox"/> Unexplained body aches or chills         |
| <input type="checkbox"/> Stomach upset/aches/pains    | <input type="checkbox"/> Sore throat                              |
| <input type="checkbox"/> Persistent cough or sneezing | <input type="checkbox"/> Unexplained fatigue and/or weakness      |



## Massage Therapy Informed Consent and Client Agreement

Please read the following carefully, and initial/sign where indicated.

\_\_\_\_\_ I am aware of the benefits and risks of Massage Therapy, that it is performed for stress relief and to reduce pain and tension, and give my consent for the service I have scheduled.

\_\_\_\_\_ I acknowledge that Massage Therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my Massage Therapist of any changes in my health status. My Massage Therapist is not liable for any pertinent information I have not properly relayed.

\_\_\_\_\_ I understand that my Massage Therapist does not and will not diagnose illness, disease, or any other physical or mental disorder, nor does my Massage Therapist prescribe medical treatment or pharmaceuticals. I understand that I should see a physician/my primary healthcare provider for any physical ailment(s) that I might have.

\_\_\_\_\_ I understand that Massage Therapy is therapeutic, for health purposes, and non-sexual in nature. I understand that any illicit or sexually suggestive remarks or advances I make will result in immediate termination of the session. I understand that I will be liable to pay the full fee for the scheduled appointment, and I will not be able to re-book any further sessions with Ouroboros Massage.

\_\_\_\_\_ I understand the cancelation and no-show policies as follows:

- Clients are responsible for informing the therapist if they cannot make a scheduled appointment. Cancellations are to be made no less than 24 hours in advance of the scheduled appointment. The client will not be charged for canceling ahead of time.
- Cancellations made less than 24 hours before the client's scheduled time will result in a late cancellation fee totaling 25% of the scheduled appointment.
- For any in-studio appointment that results in a no-call/no-show, the client is responsible for paying for the full cost of the scheduled appointment. For White Glove Luxury Service and Chair Massage Event no-shows (i.e., the Massage Therapist arrives and the client is not present), the client is also responsible for the travel costs to and from their location.
- Exceptions for such things as weather and emergencies will be given on a case-by-case basis.

\_\_\_\_\_  
Client Name (Please Print)

\_\_\_\_\_  
Parent or Guardian Name if under 18 (Please Print)

\_\_\_\_\_  
Client Signature/Parent or Guardian Signature if under 18

\_\_\_\_\_  
Date