OUROBOROS THERAPEUTIC ARTS

Client Intake Form
Myofascial Release

Name:_____ Date:_____
Street Address:_____ DOB:_____
Apt. #:_____ Age:_____
City, State, Zip:_____ Mobile:_____
Email:_____ Text Appt. Reminders? Y N
Occupation:_____

Emergency Contact:_____ Relationship:_____
Emergency Contact Phone:_____

How did you hear about Ouroboros Therapeutic Arts?:_____
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:_____
  _____
- ☐ 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
- ☐ Joint Replacement
  If yes, please indicate:_____
- ☐ 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?_____

_____

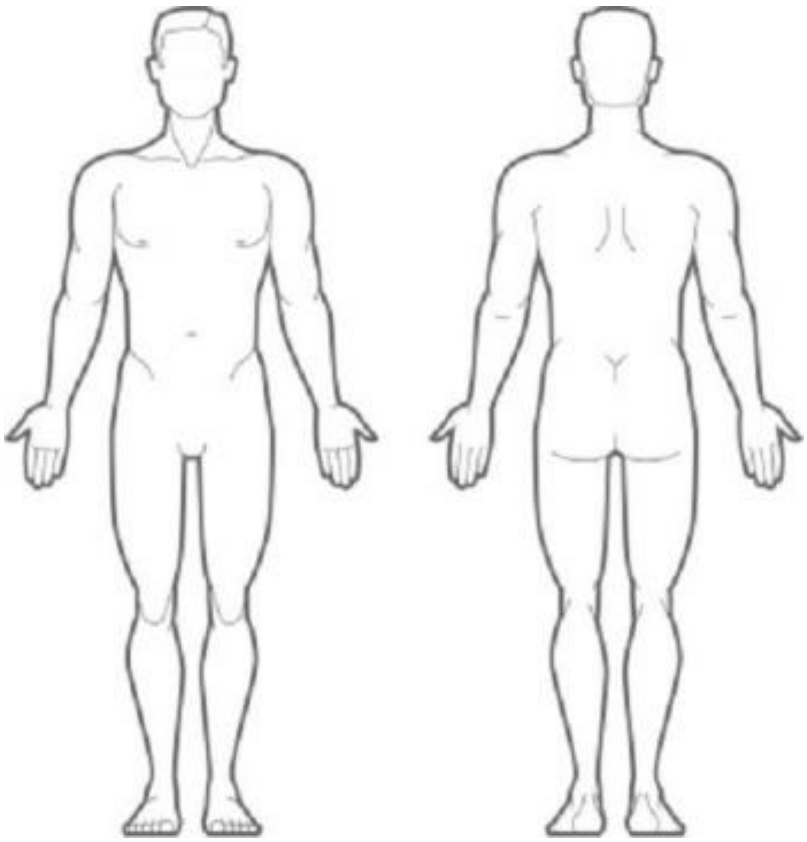
What are you looking to get out of your session today?_____

_____

On a scale of 1-10, with 1 being the best and 10 being the worst, how bad is your pain today?

1 2 3 4 5 6 7 8 9 10

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:

- ☐ Flu or flu-like symptoms
- ☐ Fever
- ☐ Stomach upset/aches/pains
- ☐ Persistent cough or sneezing
- ☐ Respiratory distress or chest discomfort
- ☐ Unexplained body aches or chills
- ☐ Sore throat
- ☐ Unexplained fatigue and/or weakness

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Please list any past or current injuries, accidents, surgeries or traumas on this page.

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 Bodywork, 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 Bodywork 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 Bodywork 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 Therapeutic Arts.

_____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 50% 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 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