

# Massage Therapy by Trisha

Trisha Jagodzinski, LMT MT 119360 ME 4450

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Email Address \_\_\_\_\_

Preferred method of contact: \_\_\_\_\_ *I value your privacy and will never share or sell your email address.*

How did you hear about me? \_\_\_\_\_ Occupation \_\_\_\_\_

Is this your first professional massage? \_\_\_\_\_ If no, how often do you receive massage? \_\_\_\_\_

What are your goals for this session? \_\_\_\_\_

Are you currently seeing a Chiropractor, Physical Therapist, or Physician? \_\_\_\_\_ Yes \_\_\_\_\_ No

If YES, please explain: \_\_\_\_\_

## Please select all that apply to you:

Frequent Headaches

Back, hip pain

Shoulder, neck, arm, hand pain

Leg, foot pain

Jaw pain/TMJ

Osteoporosis/Low bone density

Arthritis

Joint Surgery

Allergies to any lotions/oils/creams/scents

High Blood Pressure

Epilepsy/Seizures

Varicose Veins

Contagious Disease

Bruise Easily

Cardiac/Circulatory Problems

Numbness/Tingling/Stabbing Pains

Pregnant (Due Date: \_\_\_\_/\_\_\_\_/\_\_\_\_)

Other medical conditions:

**Please read carefully-** I understand that the massage therapist has the right to refuse service to anyone. I will consult my therapist with any questions or concerns immediately. I have stated all medical conditions that I am aware of and understand that I am obligated to share relevant information about my health history even if not directly asked. I will also keep my therapist informed of any changes. I understand that the purpose of this massage is to reduce stress and increase relaxation. I will immediately inform the practitioner so that 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, chiropractor or other qualified medical specialist for any mental or physical ailment I am aware of. To my knowledge I do not have any conditions or injuries that would prevent me from receiving a massage, nor have I been told by a health care provider that I cannot receive massage therapy.

I also understand that the massage therapist abides by the regulations set forth by the Texas Department of State Health Services and the following applies: Treatments may use traditional Swedish techniques such as: Effleurage, Petrissage, Tapotement, Friction, and Vibration, as well as Stretching, Hydrotherapy, Compression, and any other techniques deemed appropriate and acceptable by the state regulatory board. The therapist will not engage in breast massage of female clients. Appropriate draping will be used and only the areas being worked will be exposed at any given time. If the client or therapist is uncomfortable for any reason they have the right to terminate the session immediately. If any of the information provided here changes or the reason for treatment changes I understand I must notify the therapist and fill out a new intake form.

All services provided are NON-SEXUAL. Any and all inappropriate sexual advances (physical or verbal) will be cause for immediate termination of the session and the full service fee will be due.

**Cancellation Policy:** 24 Hours notice is required for all cancellations in order to avoid a \$25 cancellation fee. I understand that my session will begin and end at the appointed times. If I arrive up to 15 minutes late for my appointment, I will receive the remainder of my appointment and the full service fee will be due. Should I arrive more than 15 minutes late for my appointment, my appointment will be forfeited (at the sole discretion of the therapist) and the appropriate cancellation fee will be due.

Client Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_