Foxfire Mobile Massage

Client Intake Form

Client Information

Name: _____ Date: ____ / ____ / ____

Occupation: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____. Zip Code: _____

Phone: _____ Email: _____

Would you like to be added to our email list for news and exclusive offers?

- ☐ Yes
- ☐ No

By law we are required to have a copy of your photo identification and to check that you are you before the start of a session. We can't work on robots, they don't have soft tissue.

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Client Medical Information

Do you have any of the following conditions? Please explain on the lines provided.

- ☐ Arthritis / joint disorder
- ☐ Artificial joint _____
- ☐ Atherosclerosis
- ☐ Blood disorder
- ☐ Back / neck problems _____
- ☐ Cancer
- ☐ Carpal Tunnel Syndrome
- ☐ Circulatory disorder
- ☐ Contagious skin condition _____
- ☐ Decreased Sensation _____
- ☐ Deep Vein Thrombosis
- ☐ Diabetes
- ☐ Easy bruising
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Fibromyalgia
- ☐ Headaches / Migraines
- ☐ Heart Condition
- ☐ High / Low blood pressure
- ☐ Immune Disorders
- ☐ Keloid scarring
- ☐ Osteoporosis
- ☐ Phlebitis
- ☐ Pregnant
- ☐ Recent accident / injury _____
- ☐ Recent fracture _____
- ☐ Seborrheic dermatitis
- ☐ Seizure disorder
- ☐ Skin disease / lesions _____
- ☐ Sprains / strains _____
- ☐ Swollen Glands
- ☐ Tennis Elbow
- ☐ TMJ
- ☐ Varicose veins

Any other illness / condition? _____

_____

Any recent surgery, including plastic surgery?

- ☐ Yes
- ☐ No

_____

Have you had a professional massage before?

- ☐ Yes
- ☐ No

Do you have difficulty lying on your front, back, or side

- [ ] Yes
- [ ] No

Do you have any allergies to nuts, oils, lotions, or ointments?

- [ ] Yes
- [ ] No

Do you have sensitive skin?

- [ ] Yes
- [ ] No

Are there any areas you do not want massaged?

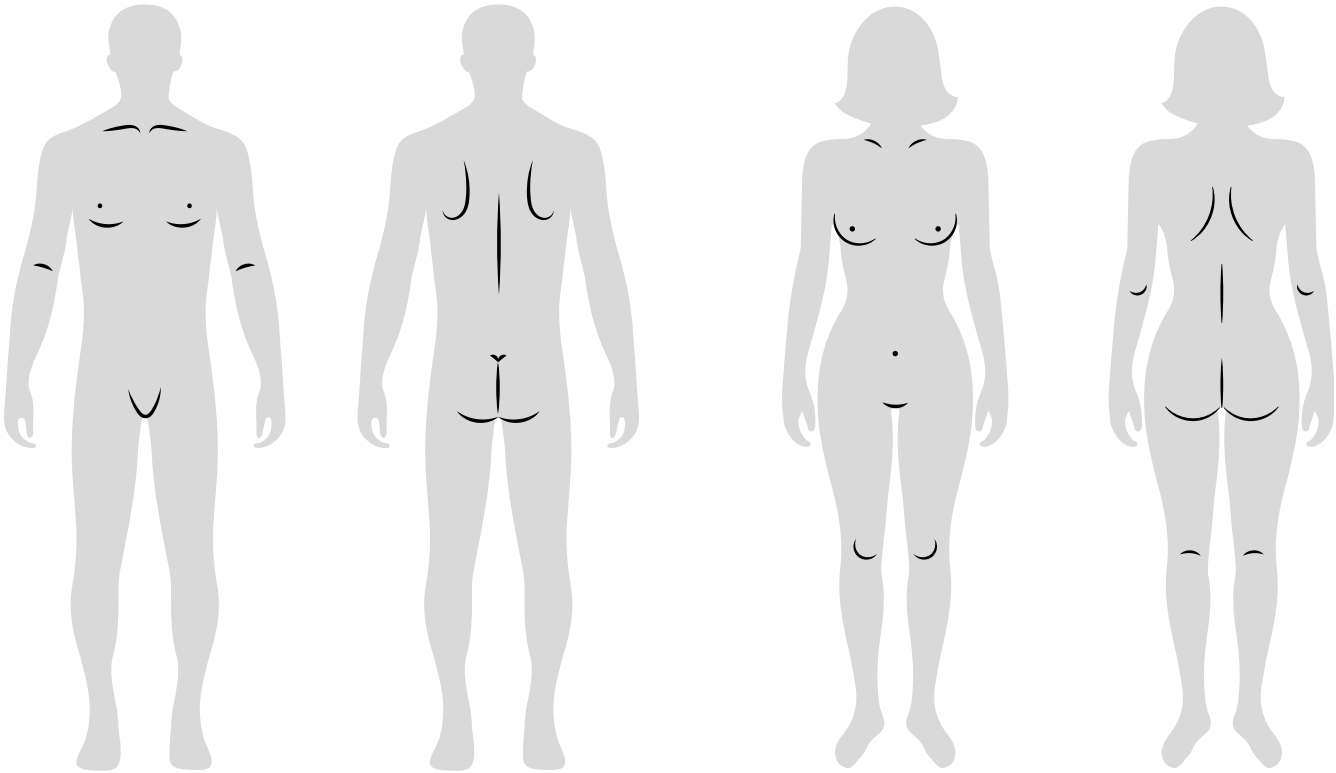
What is your goal for this massage?

- [ ] To relax and unwind
- [ ] To help alleviate pain in a specific area
- [ ] To move more fluidly

What pressure do you prefer?

- [ ] Light - superficial, just on the skin. Affects lymphatic system promoting better circulation of lymphatic fluids.
- [ ] Medium - slightly deeper than skin. Affects muscles, tendons, myofascia, and blood. It releases tension and stretches muscles.
- [ ] Deep - to the bone, not through the bone. A slower approach in which the therapist sinks their elbows or knuckles deep into the muscle to help release areas closer to the bone.

Mark any specific areas you would like your therapist to concentrate on.



Notes:

_____

_____

_____

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Client Consent Form

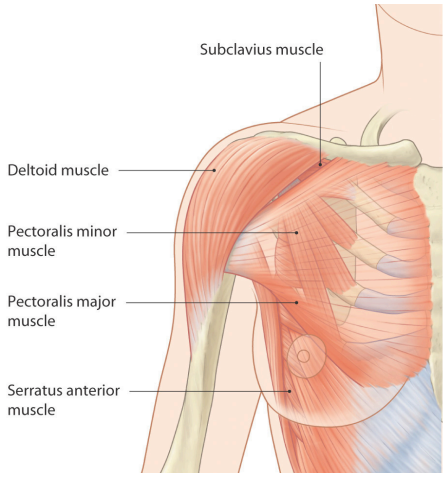
Scope of Practice

Massage Therapy is a profession in which the practitioner applies manual techniques upon the soft tissues of the body. Soft tissue includes muscles, tendons, lymphatic system, blood vessels, and visceral organs. Massage therapists do not diagnose or prescribe treatments. We offer hints and insights that the client can explore with their physicians to help alleviate their ailments.

Medical Conditions

Certain conditions such as fever, skin conditions, high blood pressure and bone fractures are contraindications for massage therapy. Being under the influence of alcohol or drugs, especially those that affect sensation or cognition is also a contraindication. It is the responsibility of the client to keep their massage therapist informed of any medical treatments they are currently prescribed. It is their responsibility to provide written permission from their doctor to continue massage therapy, as in case for cancer. It is the client's responsibility to inform the massage therapist of any changes in their health conditions.

Client Consent



Pectoral Region

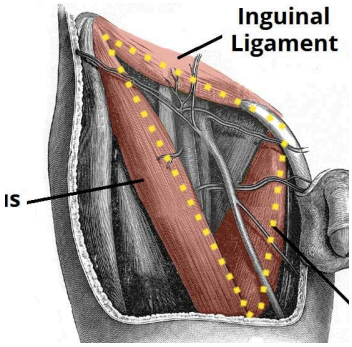
Treatment of the shoulders and back areas may include the pectoral region. This includes the breast and underarms areas. Do you consent to treatment in this region?

- ☐ Yes
- ☐ No

Signature:

_____

Date: _____ / _____ / _____



Femoral Triangle

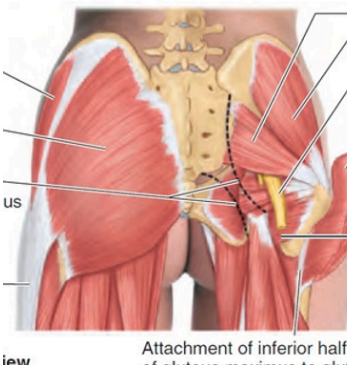
Treatment of legs, hips, lower back, and viscera may include the femoral triangle and buttocks regions. Do you consent to treatment in these regions?

- ☐ Yes
- ☐ No

Signature:

_____

Date: _____ / _____ / _____



Buttocks

Please initial to acknowledge that you have been informed of the following:

_____ I understand that if I experience any pain or discomfort during the session, I will immediately inform the therapist so adjustments can be made to my level of comfort.

_____ I understand that massage therapy is not a substitute for a medical exam, diagnosis, or treatment.

_____ Massage should not be performed under certain medical conditions. I affirm that I have stated all my known medical conditions and have answered all questions honestly.

_____ I will keep my massage therapist updated as to any changes in my medical profile and understand that there shall be no liability on the massage therapist should I fail to do so.

_____ This is a therapeutic massage session and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.

_____ I understand my massage therapist reserves the right to refuse services to me for any reason they deem necessary.

My signature acknowledges that I have read and agree to receive the massage therapy and that I will agree adhere to all the aforementioned statements that I have initialed.

Client Name: _____

Client Signature: _____ Date: _____ / _____ / _____

Therapist Signature: _____ Date: _____ / _____ / _____

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Cancellation Policy

Cancellation Policy

Our goal is to provide quality care in a timely manner. In order to do so, we have had to implement an appointment / cancellation policy.

Appointments are in high demand and your early cancellation will give another person the opportunity to have access to timely care. This policy enables us to better utilize available appointments for our clients.

At the time of booking your appointment, you will be asked to pay a **deposit** of **$25** that will be credited towards your treatment. Time has been specifically reserved for your appointment. If you need to cancel or reschedule, you must call at least 4 hours prior to your appointment and your deposit will either be refunded or pushed for a future appointment. However, providing less than 4 hours notice will require you to pay a **$50 cancellation fee.**

We are happy to answer any questions regarding this cancellation policy.

I have read and fully understand the above appointment cancellation policy and agree to be bound by its terms. I agree to pay the cancellation fee in the event of a missed appointment.

Client Name: _____

Client Signature: _____ Date: _____ / _____ / _____

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Photography and Video Release Form

Client Information

Name: _____ Date: _____ / _____ / _____

Phone: _____ Email: _____

There are times when I will ask to take your picture or video for postural assessment. These pictures help me evaluate which areas need work and formulate a plan for your massage therapy treatment. These pictures or video will be part of your medical files and will not be shared with anyone without your written authorization.

There will be no pictures, video, or recordings of your session.

Pictures of you, fully clothed, with me and or my logo is what I'm asking permission for. I would like your permission to use these photos or videos for advertising: as part of a portfolio, online posts as in Facebook, or Instagram, and print advertisements. Your consent is necessary regarding this. I would also like to tag my clients in photos used on our Facebook or Instagram profiles. Please indicate if you would like to allow this or not below.

- ☐ Yes, feel free to use my pictures.
  - ☐ Yes, please tag me on Instagram and Facebook.
- ☐ No, please do not use my pictures.

Name: _____

Signature: _____ Date: _____ / _____ / _____