LAKEVIEW
EST-2012
MASSAGE & THERAPY

NEW CLIENT FORM

Name ______________________ Phone ______________________

Address ______________________ City/State/Zip ______________________

Occupation ______________________ Email ______________________

Primary Insurance ______________________

Emergency Contact ______________________ Phone ______________________

How did you hear about us? ☐ Friend/Family ☐ Online Search ☐ Radio ☐ Social Media ☐ Driving By

INFORMED CONSENT FOR TREATMENT

☐ I understand that the massage therapist is providing massage & therapy services within their scope of practice as defined by the State of Louisiana.

☐ I hereby consent for my therapist to treat me with massage therapy including any assessments, examinations and techniques, which may be recommended, by my therapist.

☐ I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing.

☐ I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I also acknowledge that with any treatment there can be risks and I assume those risks.

☐ I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

☐ I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

☐ I have read the above noted consent. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and any such additional treatment as proposed by my service provider to deal with my physical condition and for which I have sought treatment. I understand that I and/or the therapist may terminate the session at any time and treatment will be stopped.

Client Signature ______________________ Date ______________________

Parent/Guardian Concent (If Under 18 Years of Age)

I, ______________________ authorize my specialist to perform the service on ______________________ (MINOR).

Parent/Guardian Signature ______________________

Policies & Procedures

Please review the following policies and procedures for our first-time & regular massage clients of Lakeview Massage & Therapy.

At Lakeview Massage & Therapy, your appointments are reserved for YOU. We have these policies in place to provide the best possible services for our clients. Thank you for understanding. In our commitment to provide a relaxing and outstanding massage experience for all of our clients and out of consideration for our therapists, we have adopted the following policies:

ARRIVAL TO YOUR MASSAGE - Please arrive for your appointment 15 minutes prior to the scheduled starting time. This allows you the time to fill out the appropriate client intake form (new clients) and any other prep necessary. All massages have a specific time schedule and early arrival allows for a relaxed and unhurried experience.

If late arrival is inevitable, your service may be shortened within the originally reserved time in order for our therapists to keep on schedule. The full time will still be charged. A phone call, if running late, is always appreciated.

APPOINTMENT INFORMATION - An active credit card is required to have on file in order to reserve all appointments. Cancellations made less than 24 hours before the scheduled appointment time will be charged FULL PRICE of all services booked. NO SHOWS, appointments CANCELLED or RESCHEDULED within 24 HOURS will be charged in FULL for all services booked. You are responsible for keeping your appointment times, we cannot guarantee reminders.

Rescheduling day of is considered a cancellation and the card on file will be charged the FULL price of service.

LATE ARRIVAL POLICY - Please call us if you're running late. In order to remain on schedule for all our clients, your massage therapy session will be shortened within your service time if you are late for your appointment. The regular service price will still apply.

Client Signature ______________________________ Date ______________________

Parent/Guardian Concent (Under 18 Years of Age)

I, ________________ authorize my specialist to perform the service on ____________ (MINOR).

Parent/Guardian Signature ____

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Medical History

Name ______________________ Date ______________________

The following information will help us plan a safe and effective therapy session.

Please answer the following questions to the best of your knowledge.

Have you had a professional massage before? ☐ Yes ☐ No

How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is your stress level right now? ☐ Low ☐ Average ☐ Somewhat Stressed ☐ Very Stressed

What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep

Do you have any difficulty lying on your front, back or side? ☐ Yes ☐ No

If yes, please explain ______________________

List current medications & the conditions they are treating:

____

____

Please tell us about any allergies or hypersensitivities:

____

Do you have any allergies to oils, lotions, or ointments? ☐ Yes ☐ No

If yes, please explain ______________________

Do you have sensitive skin? ☐ Yes ☐ No

What do you consider your skin type? ☐ Normal ☐ Oily ☐ Acne ☐ Dry ☐ Aging ☐ Combination ☐ Sensitive ☐ Rosacea ☐ Other

Do you sit for long hours at a workstation, computer, or driving ☐ Yes ☐ No

Do you perform any repetitive movement in your work, sports, or hobby? ☐ Yes ☐ No

If yes, please explain______________________

List any major accidents or surgeries

____

____

Physician Name: ______________________ Phone______________________

If needed, do we have a release form on file from your physician? ☐ Yes ☐ No

Is there anything else you think our therapists should know for a safe and effective session?

____

LAKEVIEW EST-2012 MASSAGE & THERAPY

Medical History

GENERAL STATE OF HEALTH

Do you smoke? ☐ YES ☐ NO
Do you exercise regularly? ☐ YES ☐ NO
Are you drinking enough water? ☐ YES ☐ NO
How many cups a day?_____
Do you drink alcohol? ☐ YES ☐ NO
How many drinks a day?_____
Are you on any special diet? ☐ YES ☐ NO

FEMALES ONLY

Could you be/are you pregnant? ☐ YES ☐ NO
If yes, how far along? _______________

PLEASE MARK ALL THAT APPLY TO YOU

- ☐ Headaches / migraines
- ☐ Vertigo / dizziness
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Asthma Shortness of breath
- ☐ Sensory loss / change
- ☐ Numbness / tingling
- ☐ Epilepsy
- ☐ Seizures
- ☐ Multiple sclerosis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Tendonitis
- ☐ Pins/ Plates/ Artificial...
- ☐ Joint
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack
- ☐ Stroke
- ☐ Heart disease
- ☐ Poor circulation
- ☐ Pacemaker
- ☐ Hepatitis
- ☐ HIV / AIDS
- ☐ Herpes
- ☐ Tuberculosis
- ☐ Lyme disease
- ☐ Infectious skin conditions
- ☐ Cancer
- ☐ Diabetes
- ☐ Digestive conditions
- ☐ Chronic fatigue syndrome
- ☐ Depression Anxiety
- ☐ Pregnant
- ☐ Given birth
- ☐ Gynecological problems
- ☐ Other conditions

____

____

Please indicate current problem areas in your body by marking on the diagrams below.

INTENSITY OF PAIN:

1 2 3 4 5 6 7 8 9 10

PRIMARY AREA OF PAIN:

☐ Adhesion ☐ Spasm ☐ Rotation ☐ Inflammation
☐ Pain ☐ Trigger point ☐ Tender Point ☐ Elevation

TIME PATTERN OF PAIN

☐ Constant (pain does not change)
☐ Intermittent (intensity doesn't change but comes & goes)
☐ Variable (intensity changes throughout the day)

Pain/discomfort is brought on or made worse by

____

Pain/discomfort feels better with

____