

DEEP TISSUE THAI CLIENT INTAKE FORM

Name: _____
Date: _____
Address: _____ City: _____ Postal Zip Code
Phone number: _____
Email: _____
Age: _____ Date of Birth (D/M/Y) _____ Sex: M / F
Emergency Contact (Name & Phone#): _____

Please answer the following questions:

What is your primary health concern?

Are you presently under the care of a medical doctor or health practitioner?

Are you on any form of medication?

Do you have any restriction in movement?

Are there any stretches or yoga postures that may be harmful?

Are you pregnant? _____ Due date: _____ Do you wear or have: Contact lenses _____ Pace maker _____ An IUD _____ Are you currently on your cycle _____

- | | | |
|--|--|--------|
| <input type="checkbox"/> Cervical spine problems | <input type="checkbox"/> Headaches | Other: |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Varicose veins | |
| <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Difficult digestion | |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Aortic aneurysm | <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Recent surgery | <input type="checkbox"/> Joint problems | |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Liver/Gall Bladder | |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Tooth/jaw pain | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney/Bladder | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Auto Immune | |
| <input type="checkbox"/> Click/Pop-Ears/Jaw | <input type="checkbox"/> Hepatitis A/B/C | |
| <input type="checkbox"/> Open wounds/cuts | <input type="checkbox"/> Dislocation | |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Fractures | |
| <input type="checkbox"/> Skin disease | <input type="checkbox"/> Hemophilia | |
| <input type="checkbox"/> Phlebitis (DVT) | | |

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The following information will be used to help plan safe and effective massage sessions.

Please answer the questions to the best of your knowledge.

1. Have you had a professional massage before? Yes No

If yes, how often do you receive massage therapy?

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

If yes, please explain:

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

If yes, please explain:

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses () dentures () a hearing aid () ?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No

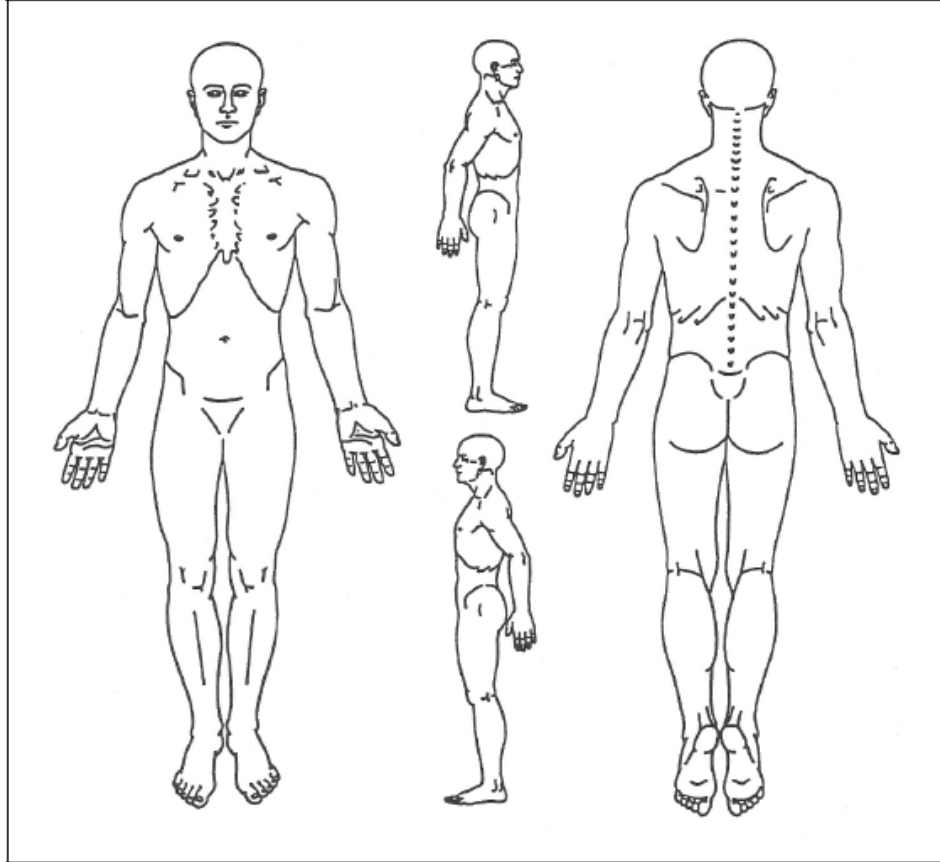
If yes, please describe

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

If yes, please describe

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Please **circle** the figures below indicating areas of your body where you are experiencing pain.



Have you had a recent major surgical procedure or injury? ____ Yes ____ No
Please Explain:

Are you currently seeing a Chiropractor, Physical Therapist, or Physician for an ongoing issue?
____ Yes ____ No

Please Explain:

Please circle your stress level: Low 1 2 3 4 5 High

What do you hope to have addressed by visiting a Thai Massage practitioner?

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Consent for Thai Massage :

It is understood that the purpose of Deep Tissue Thai Massage is for relaxation and that it is not meant to diagnose or treat any illness, disease, or any other physical or mental disorder, injury, or condition. I have informed Matthew Wakem about my state of health and I have transmitted any recommendations and restrictions on the part of my medical doctor or therapist insofar as massage is concerned. I understand that if I become uncomfortable for any reason that I may ask Matthew to end the massage session, and he will end the session. Client agrees to immediately inform Matthew of any unusual sensation or discomfort so that the application of pressure may be adjusted to Client's level of comfort. I am aware that Deep Tissue Thai bodywork can be deep and painful at times and that I am here voluntarily.

Client hereby assumes fully responsibility for receipt of the massage therapy, and releases and discharges Matthew Wakem from any and all claims, liabilities, damages, actions, or causes of action arising from the therapy received hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the Therapist, to the fullest extent allowed by law. Client, in signing this consent for Therapy and Waiver of Liability ("Consent"), understands and agrees that this Consent will apply to and govern the current and all future therapy sessions performed by Matthew Wakem.

Client Signature _____ Date _____

Client Printed Name _____

Massage Therapist Signature _____ Date _____

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Health Information–COVID-19 Information & Liability Waiver

Client Name: _____ Date: _____

COVID-19 Information

1. Have you had a fever in the last 24 hours of 100°F or above? Yes No
2. Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath? Yes No
3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes No
4. Have you been vaccinated? Yes No How Many times ? _____

Consent for Treatment

I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner.

Client Signature: _____

Date: _____

Parent or Guardian Signature (in case of a minor): _____

Date: _____

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