THAI COMPRESSION THERAPY™ 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_______

____Cervical spine problems
____High blood pressure
____Menstrual problems
____Rheumatoid arthritis
____Aortic aneurysm
____Recent surgery
____Heart disease
____Hernia
____Tooth/jaw pain
____Stroke
____Diarrhea
____Click/Pop-Ears/Jaw
____Open wounds/cuts
____Arteriosclerosis
____Skin disease
____Phlebitis (DVT)

____Headaches
____Varicose veins
____Difficult digestion
____Osteoporosis
____Constipation
____Joint problems
____Liver/Gall Bladder
____Cancer
____Arthritis
____Kidney/Bladder
____Auto Immune
____Hepatitis A/B/C
____Dislocation
____Fractures
____Hemophilia

Other:

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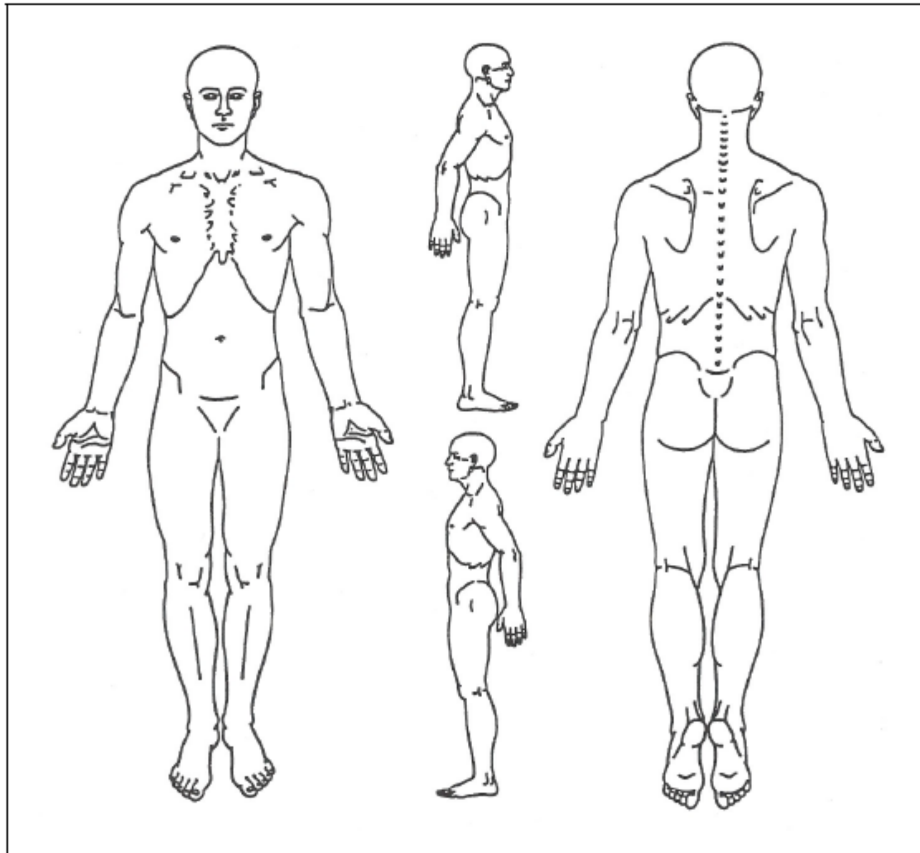
Please **circle** the figures below indicating areas of your body where you are experiencing pain.



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 Compression Therapy™:

It is understood that the purpose of Thai Compression Therapy™ 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 (also referred herewith as "Client") 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 therapy is concerned. I understand that if I become uncomfortable for any reason that I may ask Matthew Wakem to end the massage session, and he will end the session. I agree to immediately inform Matthew Wakem of any unusual sensation or discomfort so that the application of pressure may be adjusted to my level of comfort. I am aware that Thai Compression Therapy™ can be deep and painful at times and that I am here voluntarily.

Client hereby assumes full 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 Matthew Wakem, 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. Any information or advice given at any time by Matthew Wakem is not to be considered medical advice and is not intended to replace consultation with a qualified medical professional.

Client Signature_______________________________________

Date_____________

Client Printed Name

____

Massage Therapist

Signature________________________________Date_____________