



# Divine Lotus Massage

1001 Washington St. Suite 3

Eugene, OR 97401

Phone: 406.788.1660

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## Client Intake Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referred by: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Birthday: \_\_\_\_\_

Occupation: \_\_\_\_\_ E-mail: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you received massage therapy before? \_\_\_\_\_ If so what type? \_\_\_\_\_

Would you like to receive our monthly e-newsletter with special offers? ☐ yes ☐ no

Please mark past (p) or current (c) conditions which apply to you:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Numbness      | <input type="checkbox"/> Skin disorders        | <input type="checkbox"/> Allergies     |
| <input type="checkbox"/> Athlete's Foot     | <input type="checkbox"/> Stroke        | <input type="checkbox"/> Communicable Diseases | <input type="checkbox"/> Spinal Injury |
| <input type="checkbox"/> TMJ Disorder       | <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Osteoarthritis        | <input type="checkbox"/> Bursitis      |
| <input type="checkbox"/> Indigestion        | <input type="checkbox"/> Fatigue       | <input type="checkbox"/> PMS Syndrome          | <input type="checkbox"/> Headaches     |
| <input type="checkbox"/> Fibromyalgia       | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Sleep Disorders       | <input type="checkbox"/> Broken Bone   |
| <input type="checkbox"/> Varicose Veins     | <input type="checkbox"/> Asthma        | <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Sciatica      |
| <input type="checkbox"/> Constipation       | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Cancer        |
| <input type="checkbox"/> Plantar Fascitis   | <input type="checkbox"/> Depression    | <input type="checkbox"/> Compromised Immunity  | <input type="checkbox"/> Anxiety       |
|   | <input type="checkbox"/> Stiffness     | <input type="checkbox"/> PTSD                  |  |

Are you currently under a physician's care? For what? Please explain any current health problems.

Please list any surgeries, accidents or major illnesses in the last two years.

Are you taking any medications, vitamins, or supplements?

What are the primary sources of stress in your life? Where in your body do you hold stress?

What do you do to relax? What do you do to exercise?

What are your current goals for massage?

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### Informed Consent and Business Agreement

Full Payment is due at the time of treatment. A cancellation must be made 24 hours in advance to avoid charges. You are responsible for half the cost of an appointment cancelled within 24 hours and full price of an appointment missed without cancellation. Payments must be made before receiving further treatment. In the case that you are using health or auto insurance to pay for a portion of your care in this office, an arrangement may be made to omit payment and await reimbursement. We are often unable to predict these costs exactly, and may not know for 12 weeks up to 6 months after the date of service, once your company has processed the claim. By signing below, I accept financial responsibility for any outstanding charges that are not covered by my company and I authorize my provider, \_\_\_\_\_, to release my medical records relating to claim for benefits submitted.

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications, or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health. I hereby give my consent to receive therapeutic massage.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_