

Client-Practitioner Agreement

What clients can expect from me:

- ☞ A professional environment and attitude will be maintained at all times.
- ☞ I will devise a treatment plan that is specific to each client's needs.
- ☞ I will keep accurate records and review each client's file before his or her session.
- ☞ I will do my best to provide a comfortable, relaxing environment that suits each client's needs.
- ☞ I will charge a fair price for the service I provide, but I will be open to lowering my rate and/or bartering with certain clients if there is an honest need for this.
- ☞ My supplies and equipment will always be clean and safe.
- ☞ I will always respect the client's privacy and maintain confidentiality at all times.
- ☞ I will always use proper draping techniques during sessions, and only the parts of the body being worked on will be undraped at any time.
- ☞ If I need to cancel an appointment, I will notify the client within 24 hours whenever possible. If I cannot keep an appointment due to an emergency, the client will receive a 30% discount on his or her next session.

My requirements of clients:

- ☞ A professional attitude must be maintained at all times.
- ☞ Please bathe the same day as your appointment!
- ☞ Please be on time or a few minutes early. If the client arrives late, the session will still end at the appointed time and will remain at full price.
- ☞ If you need to cancel an appointment, please give 24 hours' notice or you will be charged for the appointment unless it can be filled. Emergency cancellations are determined at the practitioner's discretion.
- ☞ Please do not come to your session under the influence of alcohol or drugs.
- ☞ Payment (by personal check or cash) is expected at the time the service is rendered.
- ☞ Please turn off your cell phone unless you are expecting an emergency call!

Client name: _____

Client Signature: _____ **Date:** _____

Susan B. Graves, LMT

Practitioner Signature : _____ **Date:** _____

Client Intake Form

Personal Information

Name: _____ Today's Date: _____

Address: _____ Best Phone: _____

City/State/Zip: _____ 2nd Best Phone: _____

Email: _____ Birthday: _____

Occupation: _____ Health Care Provider: _____

Emergency Contact: _____ Phone: _____

Massage History and Treatment Information

Have you ever received a professional massage? yes no

Which of the following are you looking for from massage?

stress reduction release of muscular tension increased circulation and lymph flow for better immune function increased flexibility and range of motion pain relief from specific condition

What is your chief complaint today? _____

What do you do for exercise and how often? _____

Are you on any medications (including aspirin, ibuprofen, etc.)? _____

Have you had any accidents or surgeries? Please list the year and what kind of treatment you received.

Health History (check all that apply and briefly describe)

Musculoskeletal

- bone or joint disease _____
- tendonitis _____
- bursitis _____
- broken/fractured bones _____
- arthritis _____

- sprains/strains _____
- low back, hip, leg pain _____
- neck, shoulder, arm pain _____
- headaches/migraines _____
- spasms/cramps _____

- jaw pain/TMJ _____
- other _____

Circulatory

- heart condition _____
- varicose veins _____
- blood clots _____
- high blood pressure _____

- low blood pressure _____
- lymphedema _____
- other _____

Respiratory

- breathing difficulty _____
- sinus problems _____
- allergies _____
- other _____

Infectious Disease

- disease name(s): _____
- _____

Skin

- allergies _____
- rashes _____
- athlete's foot _____
- warts _____
- other _____

Digestive

- constipation _____
- gas/bloating _____
- irritable bowel syndrome _____
- other _____

Nervous System

- herpes/shingles _____
- numbness/tingling _____
- chronic pain _____
- fatigue _____
- sleep disorders _____
- other _____

Reproductive

- pregnant? stage _____
- PMS _____
- other _____

Other

- cancer/tumors _____
- diabetes _____
- auto-immune disease _____

- eating disorders _____
- drug/alcohol addiction _____
- nicotine/caffeine addiction _____

It is my choice to receive massage therapy. I understand that the benefits of massage include: stress reduction; relief from muscular tension, spasm and pain; increased blood, lymph and energy flow; a sense of overall well being. I agree to communicate with my practitioner any time I feel that my general wellness is being compromised.

I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Signature: _____ **Date:** _____