MASSAGE BY HAYDEN

Licensed Massage Therapist | GA MT005369

CLIENT INTAKE & SESSION PREFERENCES

CLIENT INFORMATION

Full Name

Preferred Name

Date of Birth

Phone

Email

Address

City / State / ZIP

Emergency Contact

Phone

PURPOSE OF TODAY'S SESSION

What would you most like help with today?

Primary areas of tension, discomfort, pain, or concern:

Current pain/discomfort level (0 = none, 10 = severe):

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

How long have you experienced this issue?

Have you received massage therapy previously? ○ Yes ○ No

Techniques or approaches you especially enjoy or dislike:

PRESSURE & TREATMENT PREFERENCES

Preferred pressure: ○ Light ○ Moderate ○ Firm ○ Deep ○ Varies

Areas you would particularly like addressed:

Areas you would like the therapist to avoid:

Optional areas requiring special consideration:

☐ Head/Face ☐ Neck ☐ Shoulders ☐ Chest/Pectoral ☐ Abdomen

☐ Back ☐ Hips ☐ Gluteal Region ☐ Legs ☐ Feet

HEALTH INFORMATION

Please check any condition that currently applies or may be relevant to massage therapy:

- ☐ High or low blood pressure
- ☐ Heart or circulatory condition
- ☐ Blood clot / DVT history
- ☐ Varicose veins
- ☐ Diabetes
- ☐ Neuropathy / altered sensation
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Joint replacement
- ☐ Recent fracture or injury
- ☐ Recent surgery
- ☐ Neck or back condition
- ☐ Disc or spinal condition
- ☐ Headaches / migraines
- ☐ Seizure disorder
- ☐ Cancer / cancer treatment
- ☐ Skin condition / rash / infection
- ☐ Open wound
- ☐ Fever / contagious illness
- ☐ Swelling / edema
- ☐ Pregnancy
- ☐ Allergies / sensitivities
- ☐ Other significant medical condition

Please explain checked items or other conditions the therapist should know about:

Under care of a physician, physical therapist, chiropractor, or other healthcare professional for a relevant condition?

○ Yes ○ No

Surgery, significant injury, or hospitalization within the past year? ○ Yes ○ No

Medication that may affect circulation, sensation, bleeding, pain perception, alertness, or response to massage?

○ Yes ○ No

Allergies or sensitivities to oils, lotions, fragrances, essential oils, adhesives, detergents, or other products?

○ Yes ○ No

SAFETY ACKNOWLEDGMENT

I affirm that the health information I have provided is accurate to the best of my knowledge. I agree to inform my massage therapist of relevant changes in my health, medications, injuries, pregnancy status, surgeries, or medical conditions before treatment. I understand that some conditions may require modification, postponement, or medical clearance before massage therapy.

Client Initials:

Please complete the informed consent and signature page that follows.

1. Nature of Massage Therapy

I understand that massage therapy involves manipulation of soft tissues for purposes that may include relaxation, reduction of muscular tension, improved mobility, stress reduction, and general wellness. Massage therapy is not a substitute for medical examination, diagnosis, or treatment. The massage therapist does not diagnose illness, prescribe medication, or provide medical treatment outside the lawful scope of massage therapy.

2. Communication During Treatment

I understand that massage should remain within my comfort level. I agree to communicate regarding pressure, discomfort, temperature, positioning, draping, treatment areas, or other concerns. I may ask for a technique to stop or change, or withdraw consent, at any time.

3. Draping & Professional Boundaries

Professional draping will be used. Only the area currently being treated will be uncovered as appropriate. Massage therapy provided by this practice is strictly professional and therapeutic. Sexual behavior, sexual requests, inappropriate exposure, harassment, threatening behavior, or inappropriate touching are not tolerated. The therapist may immediately terminate a session when professional boundaries or safety are violated.

4. Sensitive or Optional Treatment Areas

Areas such as the abdomen, upper chest/pectoral area, gluteal muscles, inner thigh, face, or scalp may sometimes be therapeutically relevant. Treatment will occur only when appropriate, within lawful scope of practice, and with client consent. I may decline treatment of any body area without affecting my ability to receive massage elsewhere.

5. Possible Responses to Massage

I understand that responses vary. Temporary tenderness, soreness, fatigue, emotional responses, or changes in muscular sensation may occasionally occur. I will tell the therapist immediately if I experience unusual pain, dizziness, numbness, difficulty breathing, or other concerning symptoms during a session.

6. Medical Conditions & Client Responsibility

I understand that some medical conditions may make massage inappropriate or require modification or medical clearance. The therapist may postpone, modify, or decline treatment when there is a reasonable health or safety concern. I am responsible for providing relevant health information and communicating my comfort level.

CLIENT CONSENT

By signing below, I acknowledge that I have read and understand this intake and treatment agreement; the information I provided is accurate to the best of my knowledge; I voluntarily consent to professional massage therapy; I may modify or withdraw consent at any time; and I agree to maintain appropriate professional boundaries.

Printed Name _____ **Date** _____

Client Signature _____ **Therapist Signature** _____

Therapist: Hayden Birch, LMT | Georgia Massage Therapy License MT005369

APPOINTMENT / PAYMENT / CANCELLATION ACKNOWLEDGMENT

Cancellation / rescheduling policy: _____

Late-arrival policy: _____

I understand that late arrival may reduce hands-on treatment time depending on office policy. **Client Initials:** _____

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OFFICE USE - SESSION RECORD

SESSION DETAILS

Date _____ Session Length _____ Therapist Initials _____

Primary concerns / client goals:

Assessment / observations:

Techniques / modalities / areas addressed:

Client response / outcome:

Recommendations / self-care / follow-up:

Next Appointment _____ Additional Notes _____