Alicia Moyer Bodywork
Confidential Intake & Informed Consent Form

DATE: _____

Personal Information

Name _____ Preferred Name _____Date of Birth _____

Pronouns: ☐ he/him ☐ she/her ☐ they/them ☐ other _____

Address _____City _____ State _____ Zip_____

Cell Phone _____ Home Phone _____ Email _____

Occupation _____ Referred by _____

Emergency Contact _____ Phone_____ Relationship _____

Medical Information:

Are you currently under a doctor's or therapist's care?
☐ Yes ☐ No
If so, for what illness/es or issue/s?
_____
_____
_____

Please check off any that apply to you:

- ☐ headaches
- ☐ vision problems
- ☐ sinus problems
- ☐ sprains/strains
- ☐ fatigue
- ☐ depression
- ☐ anxiety
- ☐ sleep difficulties
- ☐ pregnant
- ☐ prostate problems
- ☐ tendonitis
- ☐ chronic pain
- ☐ arthritis
- ☐ painful menstruation
- ☐ endometriosis
- ☐ scoliosis
- ☐ varicose veins
- ☐ blood clots
- ☐ high/low blood pressure
- ☐ jaw pain/teeth grinding
- ☐ cancer/tumors
- ☐ infectious disease
- ☐ skin problems
- ☐ numbness

Other:_____

Please check any of the following medications that you take:

☐ Blood pressure ☐ Blood thinner ☐ Pain killers

☐ Cortisone shots ☐ Anti-inflammatories ☐ Muscle relaxants

Massage Information:

Have you ever received a professional massage? ☐ Yes ☐ No

Reason(s) for seeking massage today?
_____
_____

What pressure do you prefer: ☐ Light ☐ Medium ☐ Firm

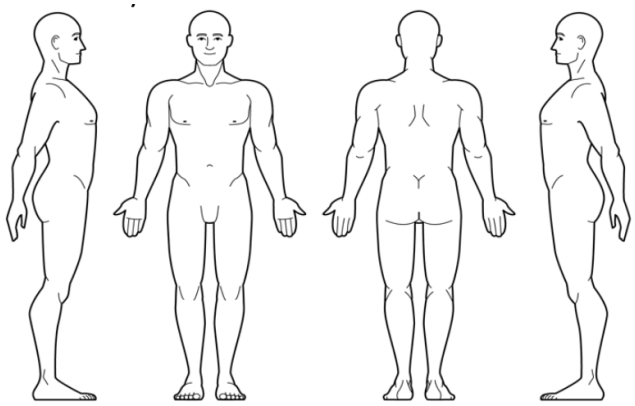
Do you have any allergies or sensitivities? ☐ Yes ☐ No
Please explain:
_____
_____

Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ Yes ☐ No
Please explain:
_____
_____

What are your goals for this treatment session?
☐ relaxation ☐ pain management ☐ stress reduction ☐ other

Please describe any injuries or surgeries that you have had (especially in the past 5 years):
_____
_____
_____
_____

Please circle or shade in where you are having pain, tension or discomfort on the diagrams below:



Indicate sensations in the areas circled such as dull or sharp, numbness, tingling, and how frequently

_____
_____

What helps alleviate this condition?

_____

What seems to aggravate the condition?

_____

List any other treatments you are receiving including acupuncture, chiropractic, physical therapy, etc.

_____
_____

What physical activities do you participate in and how often?

_____
_____
_____

Is there anything else you would like your therapist to know?

_____
_____
_____

STATEMENT OF INFORMED CONSENT

Alicia Moyer is a massage therapist in training and is not a medical doctor. I understand that massage therapy is not a substitute for medical care and that it is recommended that I consult with my primary caregiver for any health concern I may have. I have provided the massage therapist with complete and truthful information regarding all my known physical conditions and medications, and I will keep the massage therapist updated on any changes. If I am pregnant, become pregnant, or I am post-natal or post-surgical, my signature below verifies that I have my physician's approval to receive massage. I consent to receive hands-on bodywork from this therapist.

In consideration of being permitted to receive massage at Alicia Moyer Bodywork, I agree to assume full responsibility for any risks, injuries, or damages, known or unknown, which I might incur as a result of my participation. In further consideration of being permitted to receive massage at Alicia Moyer Bodywork, I expressly irrevocably release and waive any claims that I have now or may have hereafter for any reason against Alicia Moyer Bodywork, for injury or damages that I may sustain as a result of receiving massage at Alicia Moyer Bodywork.

I agree to provide **24-hour** cancellation notice and to pay the full appointment fee should I fail to do so.

Signature _____ Date _____

Signature of Parent or Guardian (if under 18) _____ Date _____

ALICIA MOYER
BODYWORK
MOVE BETTER, FEEL BETTER, LIVE BETTER