Jennifer Schade LMT

913 Gulf Breeze Pkwy. Suite 15 A Gulf Breeze, FL 32561

Name: _____ DOB:_____ Date:_____
Address:_____
Telephone:_____ Referred By:_____
Emergency Contact Name:_____ Phone_____
Email:_____
Are there any specific areas of concern that you would like special focus on today?

_____
Medications:

_____
_____
_____
Previous Surgeries:

_____
_____
_____
Please list any allergies you have: (Including drugs, lotions, food allergies, or air fresheners)

_____
_____
Please check any medical conditions that apply or any other major health conditions that may not be listed:

__Arthritis	__Kidney Disorders	__Ruptured/Bulging Disk
__Inflammation	__Blood Clots	__Seizure Disorder
__Cancer	__Varicose Veins	__High Blood pressure
__Diabetes	__High Cholesterol	__Bruise easily
__Nerve Injuries/Conditions	__Athlete's Foot	__Auto Immune Disorders
__Skin Rashes	__Eczema	__Psoriasis

__Other_____

Disclaimer: I acknowledge that it is my choice, as a client, to receive massage. I understand that bodywork and massage therapy is for the purpose of stress reduction, relief from muscular tension or spasm, for increasing circulation and energy flow. If I experience discomfort during this session, I will immediately inform the massage therapist so that pressure or strokes may be adjusted to my comfort level. I understand the massage therapist cannot diagnose any medical condition. Massage therapy is not a substitute for medical care. Please see your medical provider for any and all medical issues.

I attest that I am at least 18 years of age or older. I you are under the age of 18 please have your guardian/parent sun the waiver below to continue with your massage treatment.

If I become pregnant I authorize Jennifer Schade LMT to administer massage therapy services to me during pregnancy once I am in my 2nd trimester. I understand that the massage therapist encourages me to communicate with my physician about potential benefits and risks of prenatal massage.

I attest that the information given on this intake form is correct to the best of my knowledge. If my medical information changes, it is my responsibility to inform the therapist of any new medications, surgeries, allergies, diagnoses, or treatment that I am currently undergoing so that it may be added to my intake form

Client Signature:_____

Parent/Guardian Signature (If Under 18)_____