Massage Therapy Clinic

405 SE Bishop Blvd., Suite 102, Pullman, WA 99163
(509) 334-3444

Confidential Client Intake Form

Today's Date: _____

Client Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Email: _____

Date of Birth: _____ Occupation: _____

Emergency Contact: _____

Phone Number: _____ Relationship: _____

Preferred method of contact: ____Email ____Phone ____Text

How did you hear about us? _____

Have you received Massage Therapy before? ____ Yes ____ No

If yes, how often? _____

What are your goals for this treatment?

_____

What is your major complaint or condition you want to improve?

_____

When did this issue start? How long has this issue been bothering you?

_____

What aggravates your condition?

_____

Is it getting progressively worse?

_____

Does your condition affect:

Work? ____ Yes ____ No Sleep? ____Yes ____ No Daily Activities? ____ Yes ____ No

Who is your primary care physician? _____

Phone: _____

Injuries and/or surgeries and approximate dates:

_____

_____

What medications or vitamins are you currently taking?

_____

Any known allergies?

_____

Any other medical issues we should be aware of including those medically diagnosed?

_____

_____

Please check any conditions that apply:

- ☐ Diabetes
- ☐ Contact lenses
- ☐ Ruptured/bulging discs
- ☐ Arthritis
- ☐ Heart condition
- ☐ pins/needles/numbness/ tingling
- ☐ Seizures
- ☐ Skin disorder
- ☐ High blood pressure
- ☐ Cancer
- ☐ Varicose veins/phlebitis
- ☐ Infectious conditions
- ☐ Stroke
- ☐ Painful joints
- ☐ Auto-immune disorder
- ☐ Scoliosis
- ☐ Previous MVA/trauma
- ☐ Headache
- ☐ Loss of balance
- ☐ Fatigue/depression
- ☐ Bruxism/grinding teeth
- ☐ Other:

Are there any areas you would prefer **not** be massaged?

_____

_____

Massage Therapy Informed Consent and Disclosure

Client Name (please print): _____

By my signature below, I acknowledge that I have agreed to receive one or more massage therapy sessions from a student enrolled in the Massage Therapy Program at Altura College. I understand and agree the following:

1. Students are not licensed practitioners. These massage therapy sessions are part of required course work for students of the program. The primary purpose of these sessions is to provide students the opportunity to practice hands-on techniques and professional skills.
2. Neither Altura College nor the student shall diagnose or treat any illness, disease, or other physical or mental disorder. Nothing said or done to me by Altura College or the student should be construed as such.
3. I will provide accurate information on the forms provided. Upon return visits I will update Altura College when there are changes in my health status. I will keep the student informed of any updates to my health and will not hold the student or Altura College liable for any health changes which may occur.
4. I am responsible for obtaining medical clearance from my health care provider(s). If I have a diagnosed medical condition that could be a contraindication for massage therapy I will provide written documentation of clearance from my provider to Altura College.
5. I understand that my health history and treatment information may be discussed between the student and Altura College Faculty for educational purposes only. This information will be kept within the teacher/student relationship. My records are the property of Altura College and will be kept confidential at all times by employees and students.
6. During my session I may expect to receive benefits such as reduced muscle tension, increased range of motion, and relaxation. Neither Altura College nor the student has made any guarantees or promises about the results of my session. Any relief of physical or emotional symptoms is not a goal of these sessions.
7. I acknowledge that massage is performed directly on the skin with the use of lubricants, and that all areas of my body not being massaged will remain draped. I give Altura College and the student full permission to work on my body. I acknowledge that I also have the right to decline treatment to any part of my body.
8. I will provide the student with feedback on their massage work both during and after sessions. I will immediately inform the student if I experience any discomfort during the session, so the treatment can be adjusted.
9. Altura College has the right to terminate a session or decline to provide care in the Student Clinic at any time, and for any reason.
10. Instructor supervision is imperative for student education. I understand that instructors will be entering my massage session and agree to allow them to provide educational feedback to massage student.
11. I understand that, due to laws, students may not receive compensation for the services provided. This includes tips.
12. I understand that my appointment times are reserved for me. If I do not show up for my appointment or if I cancel within 24 hours of my appointment, I agree to pay the full $30 fee.

I understand and agree to all of Altura College's massage clinic policies.

Client's Signature: _____

Date Signed: _____