A Touch of Gold Massage & Wellness, LLC

Client Consent Form

Initial each line of this form and sign below.

_____ *If I'm arriving late to an appointment, the full appointment fee remains due, despite my arrival time*

_____ *The rescheduling or cancellation of an appointment is expected to be received at least 24 hours in advance*

_____ *I confirm that I am at least 18 years of age*

_____ *I have been given the opportunity to ask questions regarding benefits, risks, and possible complications of massage therapy*

_____ *If I feel uncomfortable for any reason during my session, I have the right to request an immediate stop to the session or request modifications to the treatment, regardless of prior consent given*

_____ *The therapist reserves the right to refuse treatment or terminate any session, over concerns of either the clients or the therapist's well-being*

_____ *I understand there is no implied or stated guarantee of success for this or future massage therapy sessions*

_____ *Fees for treatment are due prior to departure on the day of the treatment – Accepted forms of payment:* ***Cash, Zelle or Venmo***

_____ *The therapist will not be held responsible for bodily injury or a reaction due to an undisclosed condition*

_____ *I understand massage therapy is not a substitute for medical care and my therapist is not qualified to diagnose or treat any mental or physical illness*

By signing below, I confirm that I have fully read and understand the information in this consent form.

Printed Name _____ ***Signature*** _____ ***Date*** _____

A Touch of Gold Massage & Wellness, LLC

Client Intake Form

Personal Information

Name _____ DOB _____ Phone _____
Address _____ City/ST/ Zip _____
Emergency Contact _____ Phone _____ Relationship _____

Medical Information

Are you taking OTC or prescription medication? If yes, please list name and reason for use:

_____

_____

Are you currently pregnant? If yes, how far along? _____ Any high risk factors? _____

_____

Do you suffer from Chronic pain? If yes, explain: _____
What makes it better or worse? _____
Have you had any injuries? If yes, explain: _____

_____

Have you had any surgeries? If yes, Explain _____

_____

Do you have allergies? If yes, explain _____

Indicate past or present conditions:

- ❑ Diabetes
- ❑ Neuropathy
- ❑ Numbness/Tingling
- ❑ Headache
- ❑ Migraines
- ❑ Arthritis
- ❑ High/Low blood pressure
- ❑ Autoimmune Disease
- ❑ Fibromyalgia
- ❑ Stroke
- ❑ Heart condition
- ❑ Kidney Dysfunction
- ❑ Blood clots
- ❑ Varicose Veins
- ❑ Sprain/Strain
- ❑ Liver dysfunction
- ❑ Cancer
- ❑ Thrombocytopenia
- ❑ Osteoporosis
- ❑ Severe bruising
- ❑ Sunburn

Within the past 24 hours:

- ❑ Fever
- ❑ Infection (Local or systemic)
- ❑ Open wounds
- ❑ Cold/Flu symptoms
- ❑ Alcohol consumption
- ❑ Drug use

Massage Information

What is your preferred pressure? ❑ Light ❑ Medium ❑ Firm ❑ Deep
Are you sensitive to fragrances? ❑ Yes ❑ No
Are there any areas you do not want massaged? (Feet, Face, Abdomen, glutes, etc.)
❑ Yes ❑ No If yes, please list areas _____
What are your goals for this session? _____

_____

Please indicate areas of discomfort _____

By signing below, you agree that this form has been completed to the best of your ability and knowledge and you agree to inform the therapist of any changes within this form. I will not hold my therapist responsible for any conditions present, but not disclosed, prior to the session that may affect treatment.

Client Signature _____ **Date** _____