**Personal Information**

**Client Intake Form**

* **\*Full Name:**
* **\*Date of Birth (MM/DD/YYYY):**
* **\*Phone Number:**
* **\*Email Address:**
* **Preferred Contact Method:** **□** Phone  **□** Text **□** Email
* **Street Address:**
* **City** **State** **Zip Code**
* **Occupation:**
* **\*How did you hear about us?**

**Emergency Contact**

* **Name:**
* **Relationship:**
* **Phone Number:**

**Massage Preferences**

* Have you received professional massage therapy before?  
  **□ Yes □ No**
* What pressure do you prefer?  
  **□ Light □ Medium □ Firm**
* Are there any areas you would like the therapist to focus on?

* Are there any areas you would like the therapist to **avoid**?

* Are you sensitive to essential oils, scents, or lotions?  
  □ Yes □ No

**(If yes, please specify)**:

**Medical History Questionnaire**

Please complete thoroughly and check all that apply. This helps ensure your safety and the effectiveness of your session.

**General Health**

* □ High blood pressure
* □ Low blood pressure
* □ Heart disease or pacemaker
* □ Stroke or blood clots
* □ Diabetes (Type I / Type II)
* □ Cancer (current or history of)
* □ Seizures or epilepsy
* □ Migraines or frequent headaches
* □ Osteoporosis
* □ Arthritis or joint pain
* □ Varicose veins
* □ Skin conditions (eczema, psoriasis, etc.)
* □ Bruise easily
* □ Contagious diseases
* □Recent surgery or injury (past 6-12 months)

**Details** **on**

**anything checked above:**

**Musculoskeletal Health**

* □ Neck pain or stiffness
* □ Shoulder tension or injury
* □ Back pain (upper/mid/lower)
* □ Sciatica
* □ Hip pain or restrictions
* □ Knee, ankle, or foot issues
* □ Jaw pain or TMJ dysfunction
* □ Limited range of motion

**Please describe any current pain, tension, or injuries:**

**Other Conditions**

* **□** Pregnant (Weeks: )
* **□** Allergies (latex, nuts, oils, etc.)
* **□** Anxiety or depression
* **□** Insomnia or fatigue
* **□** Autoimmune disorders
* **□** Immune system concerns

**Current medications:**

**Any current or chronic medical diagnoses:**

**⚖️ Liability Waiver & Consent for Treatment**

**Please read carefully and sign below:**

I understand that the massage therapy I receive from Star Therapy, LLC is intended to support general well-being, promote relaxation, relieve muscular tension, and improve circulation and range of motion. I acknowledge that massage therapy is **not a substitute** for medical treatment, diagnosis, physical therapy, chiropractic care, or mental health counseling.

I affirm that I have **accurately disclosed all known medical conditions, physical limitations, medications, recent surgeries, and injuries** to the best of my knowledge to Star Therapy, LLC. I agree to update the therapist with any changes to my health status prior to future sessions.

I acknowledge that massage therapists do not diagnose illness, disease, or any other physical or mental disorder. As such, they do not prescribe medical treatment or perform spinal manipulations. Any suggestions or advice offered by the therapist should not be construed as a medical diagnosis or prescription.

I understand that Star Massage Therapy, LLC may include techniques involving touch and pressure and may, on occasion, cause temporary soreness or bruising, especially when working with chronic tension or injuries. I will immediately inform the therapist of any discomfort, pain, or concern so that pressure or technique can be adjusted to my comfort level.

I understand that the therapist maintains the right to end the session at any time due to inappropriate behavior, failure to disclose medical concerns, or any situation that compromises safety or comfort. I agree to respect all professional boundaries at all times.

I knowingly and voluntarily release the massage therapist, staff, and facility from any and all liability, claims, or demands arising from any injury or adverse reaction that may result from services provided, provided those services are conducted within the scope of professional practice.

I understand and agree to the **24-hour cancellation and rescheduling policy.** I may be charged a cancellation fee if I fail to provide adequate notice or do not show up for my appointment.

By signing below, I acknowledge that I have read, understand, and agree to the terms outlined above. I give my full consent to receive massage therapy services from Star Massage Therapy, LLC.

**Client Name (print):**

**Client Signature:**  **Date** Top of FormBottom of Form