INTAKE AND WAIVER LIABILITY FORM

Name:_____ Date:_____

Height:_____ Weight:_____ D.O.B:_____ Male ☐ Female ☐

Address:_____

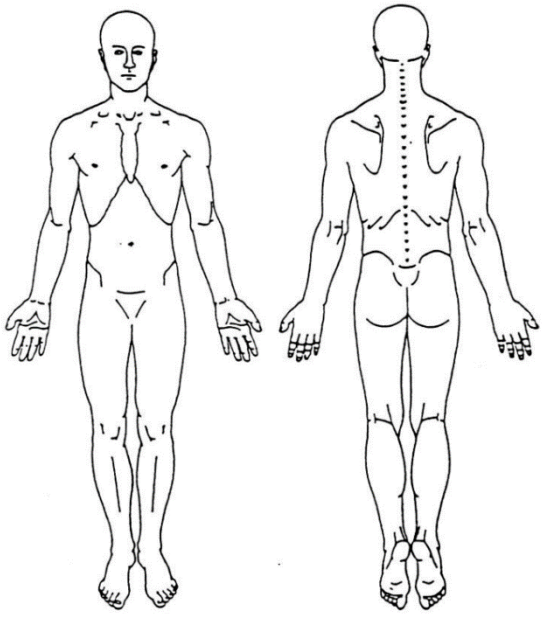
Email:_____ Phone:_____

Occupation:_____ _____

Physician:_____ Phone:_____

Emergency Contact:_____ Phone:_____

How/From Who did you hear about Manual Therapy By Emmanuelle:_____



Affected Body Area	Pain Intensity 0-10 Least to Worst	Circle: Constant, Occasional, Frequent	Circle: Sharp, Dull, Burn
1.		C O F	S D B
2.		C O F	S D B
3.		C O F	S D B
4.		C O F	S D B
5.		C O F	S D B

Check which apply to you, then briefly give dates on lines below:

Diabetes/Hypoglycemia		Urine Leakage/Urgency		Skin Abnormalities	
High Blood Pressure		Kidney Problems		Hereditary Disorders	
Heart Attack		Infections or Infectious Diseases		Hernia	
Pacemaker		Liver/Gallbladder Problems		Seizure	
A-Fibrillation		Nausea/Vomiting		Metal Implants	
Headaches		Osteoarthritis		Fracture	
Stroke		Osteoporosis		Hysterectomy	
Cancer		Rheumatoid Arthritis		Prostate Problems	
Smoking		Asthma/Breathing Difficulties		Surgeries (Please explain below)	
Phlebitis		Constipation		Fibromyalgia	

Include any other pertinent information regarding your past medical history (Please include type and date of surgery if applicable):

_____
_____
_____
_____
_____

List medications currently taken if any:_____
Do you have any allergies? (If yes, please list):_____
Describe exercise routine and frequency:_____
Are you pregnant?: Yes ☐ No ☐ If yes, Number of months:_____

Please take a moment to carefully read the following information and sign where indicated.

I, _____, (client) understand that massage therapy provided by Emmanuelle Celicout , (massage therapist) is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch.
The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.
I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I am fully aware that any illicit or sexually suggestive remarks or advances will result in immediate termination of my session and I will be liable for full payment of all scheduled treatments.

Cancellation Policy

In respect for our intention to offer high quality services at affordable rates and in respect for others in the community in need of treatment, we have a strict cancellation policy. All appointments that are rescheduled/ cancelled with less than 24 hour advance notice, and appointments that are missed without notice, will be responsible for the session's fee.

I, _____, understand that there is a 24 hour cancellation policy and that if I do not adhere to the policy, I will be responsible for the entire cost of the missed appointment.

Signature:_____ Date:_____