4645 Wyndham LN, Suite 170A, Frisco, TX 75033
254-247-8524
Aqua Webb LMT, NMT: MT108912
Adriana Morales LMT: MT119956
Kelle Baley LMT: MT127853

Name____DOB ____________________

Address____City ________________________

State________Zip_____________Phone (   )_________________Phone (   ) ________________

E-mail: ____ Email newsletters/specials? ☐ Yes ☐ No

Occupation____ Male____Female____Other_____

Referred by:____Phone (   ) ________________

In case of emergency:_____________________________________Phone (   ) ________________

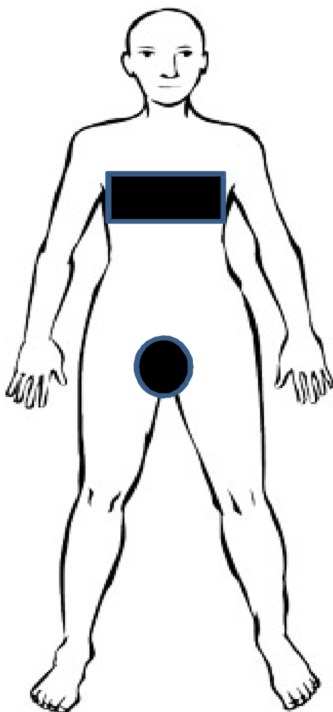
Physician______________________________________Phone (   )___________________________

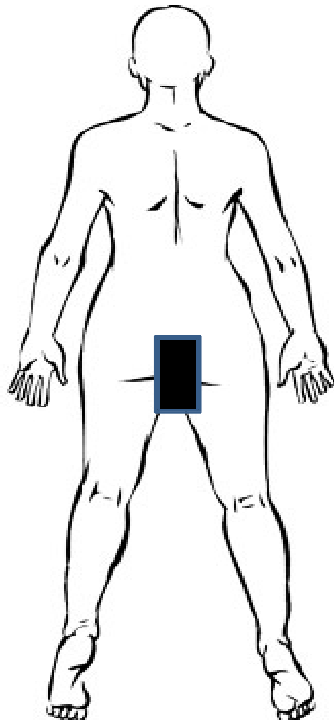
Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? ___Yes ___No   How recently?_______

What are your massage or bodywork goals? ____

What kind of pressure do you prefer? light ☐ medium ☐ firm ☐ other_____________________________





Use the body map to complete the following:

CIRCLE (O) any areas of your body that you want focused attention on.

CROSS OUT (X) any areas you would rather be avoided / not massaged during the session.

DOTTED LINE (----) any surgical or other deep / significant scar tissue.

<u>Shaded areas will not be massaged.</u>

If you answer "yes" to any of the following questions, please explain as clearly as possible.

Please list any sources of personal stress (mental, emotional, or physical):____

____

☐ Yes ☐ No Do you suffer from depression/anxiety, or any other mental illness? If yes, please list: ________________________

☐ Yes ☐ No Do you have diabetes? If yes, controlled by what means? ____

☐ Yes ☐ No Do you experience frequent headaches? How many per week/month? __________________________________

☐ Yes ☐ No Are you pregnant? If yes, how many months? ____________

☐ Yes ☐ No Do you have any allergies? Please list: ____

☐ Yes ☐ No Are you allergic to anything topically (skin)? Please list: ____

☐ Yes ☐ No Do you suffer from arthritis or joint swelling? If yes, what joints? ______________________________________

☐ Yes ☐ No Do you have osteoporosis?

☐ Yes ☐ No Are you wearing contact lenses?

☐ Yes ☐ No Do you suffer from TMJ syndrome or grind/clench your teeth?

☐ Yes ☐ No Do you have high blood high pressure? If yes, please list any medication(s): _____________________________

☐ Yes ☐ No Do you suffer from epilepsy or seizures?

☐ Yes ☐ No Do you have cardiac or circulatory problems?

☐ Yes ☐ No Do you have varicose veins? If yes, please list location: ____

☐ Yes ☐ No Do you bruise easily?

☐ Yes ☐ No Do you have any history of either cranial (head) or sacral (tailbone) trauma/concussion? Date of injury? ____________

☐ Yes ☐ No Any broken bones in the past? Please list: ____

☐ Yes ☐ No Do you suffer from back pain? If yes, is it in a specific area? ____

☐ Yes ☐ No Are you currently experiencing numbness in any area? Please list: ____________________________________

☐ Yes ☐ No Are any areas sensitive to pressure? Please list: ____

☐ Yes ☐ No Are you currently experiencing any muscle tension or soreness? List area(s): ______________________________

____

☐ Yes ☐ No Any injuries/trauma/surgeries? List type and date of occurrence: _____________________________________

____

☐ Yes ☐ No Do you suffer from any chronic problems or have any other medical condition I should know about? Please list:

____

____

Please list any medications you are taking, not listed above:____

Please read, initial and sign where indicated below

Please be advised of the policies for this office. Your signature below signifies acceptance of these policies.

Cancellation

A 24-hour notice is required for cancellation of an appointment, or you will be charged in full for the appointment. Payment is due before your next appointment.

Tardiness

Appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals.

Sickness/Injury

Manual therapy is not appropriate care for infectious or contagious illness (i.e.: poison ivy contact, common cold, influenza, covid, etc.), or after an acute injury (i.e.: car accident, sprain or broken bone, head trauma, etc.). Please cancel your appointment as soon as you are aware of an infectious or contagious condition and immediately after an acute injury. If it is within the 24-hour notice period, the cancellation fee may be waived.

Initials

______ I understand that a combination of Swedish, Deep Tissue, Trigger Point, Myofascial Release, Hot Stone, Sports/Stretching, Neuromuscular Therapy, Reflexology, Manual Lymphatic Drainage, Thai, Myoskeletal Alignment, Aromatherapy, Electronic Percussion, Cupping, PhysioKinetix, Neuromuscular Reprogramming and Spa applications MAY be used during the massage session.

______ I understand that breast massage of female clients is not within the scope of practice for Frisco Massage Therapy and will not be performed.

______ I understand that draping (including the genital area and gluteal cleavage) is required by the State of Texas and will be used during the entire massage session.

______ I understand that if I am uncomfortable for any reason during the session, I may ask for the massage to end and it will.

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said during the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. ***I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.***

Client Signature____Date_______________

Practitioner Signature____Date_______________

Consent to Treatment of Minor:

By my signature below, I hereby authorize____________________________________to administer massage, bodywork, or somatic therapy techniques to my child or dependent, as they deem necessary.

Signature of Parent or Guardian____Date___________

Practitioner Signature____Date___________