- Proper draping will be used throughout the massage session for the comfort of the client as well as the practitioner. The practitioner will undrape and massage only the necessary body parts to facilitate the massage, excluding the private areas as well as any other contraindicated areas.
- Swedish, Deep Tissue, Trigger Point, Sports, Rehab massage techniques or any other techniques that your practitioner is certified in may be used in your session.
- The practitioner will not engage in breast massage without prior written consent from the client.
- If you feel uncomfortable for any reason, you may ask the practitioner to cease the massage and the session will terminate immediately.
- Any illicit or sexually suggestive or explicit remarks or advances made by the client, whether physical or verbal, will result in immediate termination of the session and the client will be liable for full payment.

I understand that the massage 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 stroke may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage 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 understand that if I have any concerns regarding my massage therapy session, I will contact management at 713-416-3136 or by email nreyna@executivemassage.net**

Consent of treatment of Minor: By my signature below, I hereby authorize my practitioner to administer massage to my child or dependent as they deem necessary.

Consent of treatment for breast massage: By my signature below, I hereby authorize my practitioner to conduct breast massage for the sole purpose of scar reduction after breast augmentation surgery, reconstruction surgery and/or any other reason prescribed to me by my physician.

PLEASE REMEMBER TO HIT THE **'SAVE'** BUTTON AT THE TOP RIGHT OF THE PAGE BEFORE YOU CLOSE OUT

- [ ] Diabetes
- [ ] Unexplained weight loss
- [ ] Digestive conditions
- [ ] Fibromyalgia
- [ ] Chronic fatigue syndrome
- [ ] Depression
- [ ] Anxiety
- [ ] Psychiatric disorder

CARDIOVASCULAR

- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Heart attack
- [ ] Stroke
- [ ] Chronic congestive heart failure
- [ ] Heart disease
- [ ] Poor circulation
- [ ] Phlebitis / varicose veins
- [ ] Pacemaker
- [ ] Hemophilia
- [ ] Family history of cardiovascular problems

SKIN & INFECTIONS

- [ ] Hepatitis
- [ ] HIV / AIDS
- [ ] Herpes
- [ ] Tuberculosis
- [ ] Lyme disease
- [ ] Infectious skin conditions

NERVOUS SYSTEM

- [ ] Sensory loss / change
- [ ] Numbness / tingling
- [ ] Sciatica
- [ ] Epilepsy
- [ ] Seizures
- [ ] Multiple sclerosis

MUSCULOSKELETAL SYSTEM

- [ ] Arthritis
- [ ] Family history of arthritis
- [ ] Osteoporosis
- [ ] Tendonitis
- [ ] Bursitis
- [ ] Jaw pain (TMJ)
- [ ] Pins / plates / wires / artificial joint

OTHER CONDITIONS

- [ ] Cancer
- [ ] Diabetes
- [ ] Unexplained weight loss
- [ ] Digestive conditions
- [ ] Fibromyalgia
- [ ] Chronic fatigue syndrome
- [ ] Depression
- [ ] Anxiety
- [ ] Psychiatric disorder

CARDIOVASCULAR

- [ ] High blood pressure

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Center
Norma Reyna, BCTMB

CLIENT INTAKE FORM

PLEASE CHECK IF YOU ARE HAVING OR HAVE EVER EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS OR CONDITIONS

HEAD / NECK

- [ ] Headaches/migraines
- [ ] Vertigo/dizziness
- [ ] Ringing in ears
- [ ] Hearing loss
- [ ] Vision problems
- [ ] Vision loss

RESPIRATORY

- [ ] Asthma
- [ ] Shortness of breath
- [ ] Chronic cough
- [ ] Bronchitis
- [ ] Emphysema
- [ ] Sinusitis
- [ ] Frequent colds
- [ ] Smoker
- [ ] Family history of respiratory difficulties

NERVOUS SYSTEM

- [ ] Sensory loss / change
- [ ] Numbness / tingling

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CLIENT INTAKE FORM

REASON FOR VISIT

What's the primary reason for visit?

Have we treated you for this in the past?

BACK

NEXT

This form is secured with 256-bit encryption to protect your personal information.

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CLIENT INTAKE FORM

HEALTH INFO

How would you rate your general health?

Do you have any previous experience with Massage Therapy?

List current medications and the conditions they are treating

List any major accidents or surgeries (including dates)

Please tell us about any allergies or hypersensitivities

How were you referred to us?

BACK

NEXT

This form is secured with 256-bit encryption to protect your personal information.

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Norma Reyna, BCTMB

CLIENT INTAKE FORM

YOUR CONTACT INFORMATION

Street Address

City

State/Province

Texas

Country

United States

Zip/Postal Code

Home Phone

Mobile Phone

Work Phone

ABOUT YOU