Client Intake Form
Healing Radiance Massage
1216 Howard Street Omaha, NE 68102, 402.880.7618

NAME ____ PHONE# ___________

E-MAIL ADDRESS ____

ADDRESS ____

CITY ____ STATE _____ ZIP _________

DATE OF BIRTH ___________________ AGE _____ MALE ____ FEMALE ____

OCCUPATION ____

EMERGENCY CONTACT _______________________________________ PHONE # __________

REFERRED BY ____

The following health information will remain strictly the possession of Healing Radiance Massage and is collected solely to provide you with the best care possible. Please be advised that certain conditions may be contraindicated for therapeutic massage, and your session may need to be adjusted, discontinued, or rescheduled if receiving therapeutic massage would put your health or the health of the therapist at risk. Please review the following conditions and check those that apply to you:

_ HIV/AIDS
_ Anxiety/Depression
_ Cancer
_ Gout
_ Epilepsy
_ TMJ
_ Diabetes

_ Tension Headaches/ Migraines
_ Carpel Tunnel Syndrome
_ Skin Conditions: _________________
_ Heart Disease
_ High Blood Pressure
_ Fibromyalgia
_ Allergies: ______________________

_ Joint Pain
_ Arthritis
_ Muscle Pain
_ Other
_ Cold/Flu
_ Pregnancy # weeks ____
_ Varicose Veins

Please elaborate on any above condition as needed: ____
____

Please list any recent injuries or surgeries:
____

Please list any medications you are currently taking:
____

Do you have your physician's permission to receive therapeutic massage? _ yes _ no _ not necessary

I certify that the above information is correct to the best of my knowledge. I understand that Massage Therapy is not intended to substitute proper medical care. I also understand that any illicit or sexually suggestive remarks/advances made by me will result in the immediate termination of my session, yet I will be liable for full payment of the originally scheduled appointment time. I release Healing Radiance Massage from any unforeseen liability that may occur from receiving massage therapy and/or bodywork. Healing Radiance Massage reserves the right to refuse service to anyone, at any time, for any reason.

Signature____ Date ______

Consent to Treatment of Minor:
I hereby authorize Healing Radiance Massage to administer massage and/or bodywork to my child/dependent.

Signature of Parent/Guardian ______________________________ Date _______

R E L A X R E S T O R E R E J U V E N A T E R A D I A T E