PhoenixRising Therapies
Massage | Cupping | Reiki

# Client Intake Form

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LMT, CMCP, RM

Name: _____ Birthday: _____

*Please Print*

Phone: _____ _____ _____

*Cell* *Home* *Work*

Email: _____

Emergency Contact: _____ Phone: _____

What type of therapy do you want today?

- ☐ *Massage* ☐ *Hot Stone* ☐ *Prenatal*
- ☐ *Cupping* ☐ *Bamboo Fusion* ☐ *Couple's*
- ☐ *Reiki* ☐ *Himalayan Salt Stone* ☐ *Add-On*

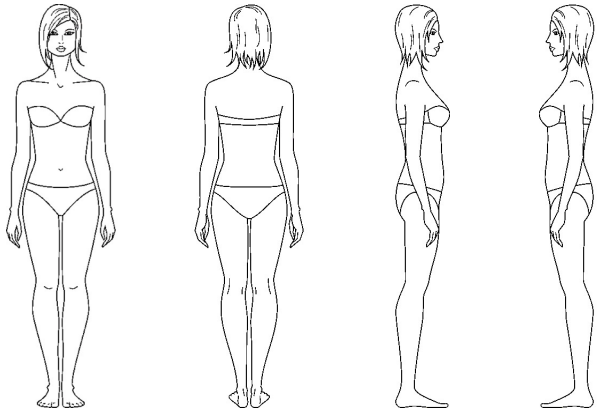
What result would you like today?

- ☐ *Relaxation* ☐ *Pain Relief*
- ☐ *Muscular Tension Relief* ☐ *Muscle Spasm Relief*

*Other:* _____

*Mark Problem Areas*

Rate Your Overall Pain *(Low 0 – High 10)*: _____



| | Yes | No | |
|---|---|---|---|
| Have you had this therapy before? | ☐ | ☐ | If yes, when? |
| Are there any areas you do not want therapy performed? | ☐ | ☐ | If yes, specify: |
| Are you pregnant? | ☐ | ☐ | If yes, how many months? |
| Are you currently under a doctor's care? | ☐ | ☐ | If yes, for what? |
| Are you currently taking any medications? | ☐ | ☐ | If yes, what? |

## Client Consent

I understand that this therapy is non-sexual and being given for the well-being of my body and mind. This includes relaxation, or relief from pain, muscle tension, or muscle spasm. I agree to communicate at any time during my therapy any discomfort or feelings that my well-being is being compromised.

I understand that illness, disease, or any physical or mental disorder will not be diagnosed, that medical treatment or pharmaceuticals will not be prescribed, and that spinal thrust manipulation will not be performed. I acknowledge that this is not a substitute for a medical examination or diagnosis of any condition.

I have stated all of my medical conditions to the best of my knowledge, and I agree to disclose any changes in my health status.

Signature: _____ Date: _____