

Acupressure Therapy Intake Form

*Name		
*Date of Birth	____/____/____	
Phone for Reminder Text		
Occupation		
Referred by:		
*Mailing Address		
*Emergency Contact Name & Number		
*Email Address		
Have you had Acupressure, Massages or Bodywork before?		
Do you have a tendency to bruise easily? We can bruise you!	Yes	No
Have you recently been exposed to a communicable disease?	Yes	No
Do you have any recent injuries? Please explain:		
List areas you WANT to focus on:		
List areas you wish NOT to have focused on:		
Are you taking any blood-clotting medication?	Yes	No
Are you taking any blood-thinning medication?	Yes	No
Any sensory altering meds?	Yes	No
How often do you work out?		

Please circle any of the following medical conditions/symptoms that apply to you:

Heart Disease	Surgeries	Immunity Related Disorder
High Blood Pressure	Herpes Simplex	Insomnia
Hospitalization	Whiplash	Hypertension
Hepatitis	Asthma	Migraines
Carpal Tunnel Syndrome	Angina	Contagious Disease
Sciatic Nerve Issues	Phlebitis/Thrombosis	Pregnancy *Special Tables Available
Stroke/Heart Attack	Fibromyalgia	Repetitive Strain Injury
Varicose Veins	Disc Problems	Arthritis - Diagnosed?
Cancer/Tumors	Diabetes	Skin Conditions
Dizziness	Allergies	Inflammation

Please describe below if any of the above pertains to your treatments today or in the future:

This is your session and you should be as comfortable as possible!

Feel free to ask any questions before, during, or after the session. We will be happy to make you feel informed and at ease!

Consent/Liability Form for Acupressure Therapy

Initials _____	Sometimes doing work on the body can bring out memories long forgotten or cause emotions to surface unexpectedly. If that happens, let us know and we will stop and we'll help you decide what to do. ♥
Initials _____	48 hour cancellation notice is required. There will be a cancellation fee without 48 hour notice, of the entire cost of the service scheduled.
Initials _____	If you have any issue with the service provided, please tell your Therapist that you want to STOP in the first TEN minutes. You will not be charged. We are not a fit for everyone and we understand this.
Initials _____	I understand that the Acupressure Treatment I receive is provided for the basic purpose of stress reduction, relief from muscular tension or spasm, and/or improving circulation. I understand that an Acupressure Therapist neither diagnoses illness, disease, or any other medical, physical, or mental disorders; nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailments I may have. I also understand that Knotty No More specializes in deep tissue bodywork and that can entail bruising, 2-3 days of recovery, and in the event of an issue, I am always welcome to contact the owner and encouraged to do so.
Initials _____	<p>Knotty No More is hereafter referred to as “the Provider.” In consideration for your participation in Acupressure Therapy, the client does hereby release and forever discharge the Provider, and its officers, board, and employees, jointly and severally from any and all actions, causes of actions, claims and demands for, upon or by reason of any damage, loss or injury, which hereafter may be sustained by receiving Acupressure Therapy.</p> <p>This release extends and applies to, and also covers and includes, all unknown, unforeseen, unanticipated and unsuspected injuries, damages, loss and liability and the consequences thereof, as well as those now disclosed and known to exist. The provisions of any state, federal, local or territorial law or state providing substance that releases shall not extend to claims, demands, injuries, or damages which are known or unsuspected to exist at this time, to the person executing such release, are hereby expressly waived. This includes the use of cupping, infrared light therapy, cold laser light therapy, pulsating electromagnetic field therapy, or the Himalayan Salt Booth.</p> <p>I hereby agree on behalf of my heirs, executors, administrators, and assigns, to indemnify the Provider and its officers, board and employees, joint and severally from any and all actions, causes of actions, claims and demands for, upon or by reason of any damage, loss or injury, which hereafter may be sustained by receiving Acupressure Therapy.</p> <p>It is further understood and agreed that said participation in the Acupressure Therapy is not to be construed as an admission of any liability and acceptance of assumption of responsibility by the Provider, its officers, board, and employees, jointly and severally, for all damages and expenses for which the Provider, its officers, board and employees, become liable as a result of any alleged act of the participant.</p>
Signature of Client	
PRINTED Name	
Date	_____/_____/_____

Please put an **X** on areas of pain.

