



MASSAGE

The Wisdom of the Body Temple



Dear Client: This form will assist in the creation of a safe session for your individual needs and a support system for your body, mind, and spirit. There are various conditions that might need your doctor's permission such as cancers or surgery. Various infections or wounds might prohibit you from having a massage until healed.

- We offer no refunds (check) ___
- We request a 24-to-48-hour notice of cancellation outside of an emergency (check) ___
- We charge half of the whole fee paid for last minute (same day) cancellations outside of an emergency with the balance being used toward your next appointment (check) ___
- You are expected to pay the entire fee online before your session when your appointment has been confirmed unless other arrangements have been confirmed to hold your space (check)___
- Do not bring children, other people, pets, or food: (check) ___
- No cell phones used during session: (check) ___
- Do not come high or altered: (check) ___
- Please download the Peacemaker Power Tools and The Ten Commitments (PDF) from the website price page (check) ___
- Create a positive intention for your massage experience: (check)___
- Please be on time (check)___
- Please love yourself deeply: (check)___
- Peacemaker is spiritually based. Peacemaker is not religious but respectful and supportive of all (check)___

We require a valid ID. Clients must be twenty years and older. We hold the right to not be of service especially in the case of sexual or verbal profanity, nudity, intoxication etc.. All information is confidential.



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*Proper Hygiene for Massage: Please bring a clean body, clean feet, hands, and mouth. If you are not coming directly from home a clean washcloth will be available for you to use if needed: Allow me to know if you have any external skin infections or infections in general before your massage begins.

Thank you for your consideration. (Check)___

I HAVE READ THE ABOVE INFORMATION AND I AGREE TO THESE TERMS: REQUIRED

PRINT _____

SIGNATURE _____

Date _____



Peacemaker Enterprise
5100 Westheimer Rd, Suite 470 Houston, TX 77056
peacemakerenterprise.com

CONFIDENTIAL



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ENTERPRISE

CLIENT INFORMATION: *Please Print*

NAME _____ BIRTH DATE _____

ADDRESS _____

HOME PHONE _____ BUSINESS _____

CITY _____ STATE _____ ZIP _____

EMAIL _____ CELL _____

OCCUPATION _____ HOBBY _____

NUMBER OF CHILDREN AT HOME _____ AWAY _____

NAME/# OF NEXT OF KIN FOR EMERGENCY _____

GENERAL HEALTH CONDITION ?

EXCELLENT ___ GOOD ___ AVERAGE ___ BELOW AVERAGE ___ POOR ___

PREGNANT _____

HAVE YOU HAD HAVE ANY SERIOUS OR CHRONIC ILLNESS ? ___ YES ___ NO

OPERATIONS ? _____

TRAUMATIC ACCIDENTS ? _____

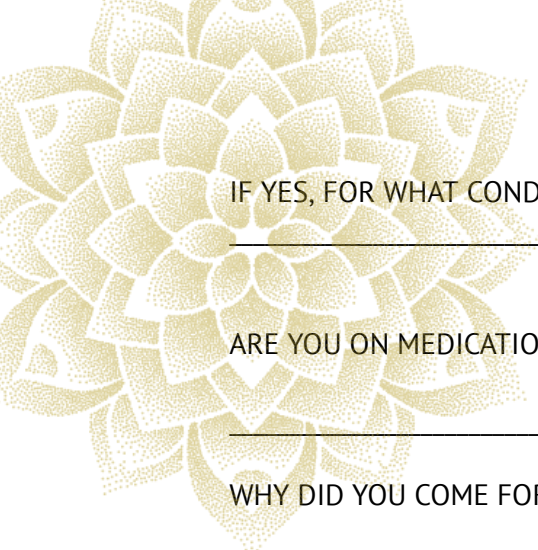
ARE YOU PREGNANT ? _____

ARE YOU UNDER A DOCTOR'S\CHIROPRACTOR OR OTHER HEALTHCARE WORKER'S

CARE ? ___ YES ___ NO

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IF YES, FOR WHAT CONDITION(S) ?

ARE YOU ON MEDICATION/S AND IF SO, WHAT KIND AND FOR WHAT ?

WHY DID YOU COME FOR THIS SERVICE ?

RELAX ___ PAIN ___ STRESS ___ PHYSICAL CONDITIONING ___

TRUAMAS : SEXUAL ___ PHYSICAL ___ RACIAL/CULTURAL ___

CIRCLE: STRESS LEVEL FROM ONE TO FIFTEEN: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

HAVE YOU HAD MASSAGE BEFORE ? ___

DO YOU PREFER YOUR MASSAGE? LIGHT ___ MEDIUM ___ DEEP TOUCH ___

DO YOU WANT WARM TOWELS ON YOUR BACK or FACE ? ___ YES ___ NO (add-on)

DO YOU WANT? OIL ___ CREAM ___ DON'T CARE ___

DO YOU HAVE A PROBLEM WITH AROMATHERAPY SCENTS ? ___ YES ___ NO

PLEASE CHECK

	Yes	No
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>
SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>
SPINAL INJURY	<input type="checkbox"/>	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>
HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>
PINS\NEEDLES	<input type="checkbox"/>	<input type="checkbox"/>
HEART CONDITIONS	<input type="checkbox"/>	<input type="checkbox"/>
SKIN DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>
VARICOSE VEINS	<input type="checkbox"/>	<input type="checkbox"/>





PLEASE CHECK (con't)

- FATIGUE
- DEPRESSION
- PAINFUL JOINTS
- PHLEBITIS
- SCOLIOSIS
- LOSS OF BALANCE
- DISK PROBLEMS
- ELEVATED CHOLESTEROL
- HIGH BLOOD PRESSURE
- INFECTIOUS CONDITIONS
- HIV, HERPES
- SEXUALLY TRANSMITTED DISEASES
- ASTHMA
- FAMILY RELATED ADDICTION
- COVID
- BLOOD CLOTS
- THROMBOSIS

Yes

No

<input type="checkbox"/>	<input type="checkbox"/>
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ENTERPRISE

Signature: _____ Date: _____

Print: _____





Mandatory Texas Massage Rules

Texas Administrative Code (TAC), Section 117.91



AGREEMENT

Checklist for Ensuring that a Massage Therapy Consultation Document Meets the Minimum Requirements Established by Rule (Circle Yes)

1. The type of massage therapy services or techniques the licensee anticipates using during the massage therapy session. Light ___ Medium ___ Moderately Deeper touch by hand/or massage tools, Dry brush _____ Yes
2. All parts of the client's body (whole body) will be massaged EXCEPT genital area, gluteal cleavage, breast , areas avoided because of contraindications or client requests such as (back massage only) Yes
3. Draping the breasts of female clients will be used during the session. Yes
4. Breast massage of female clients will not be done. Yes
5. Draping genital area and gluteal cleavage always used for clients. Yes
6. If the client feels uncomfortable for any reason, the client may ask the therapist to stop, and the therapist will end the massage session. Yes
7. The massage therapist may end the massage session if she feels uncomfortable for any reason. Yes
8. The massage therapist must immediately end the session if a client initiates any verbal or physical contact that is sexual in nature. Yes
9. Massage therapy is not a substitute for medical examination or diagnosis. It is recommended that I see a physician for any physical ailment that I may have. I understand that the massage therapist does not prescribe medical treatments or pharmaceuticals and does not perform any spinal adjustments. I am aware that if I have any serious medical diagnosis, I must provide a physician's written consent prior to services. Yes

Signature: _____
Print: _____

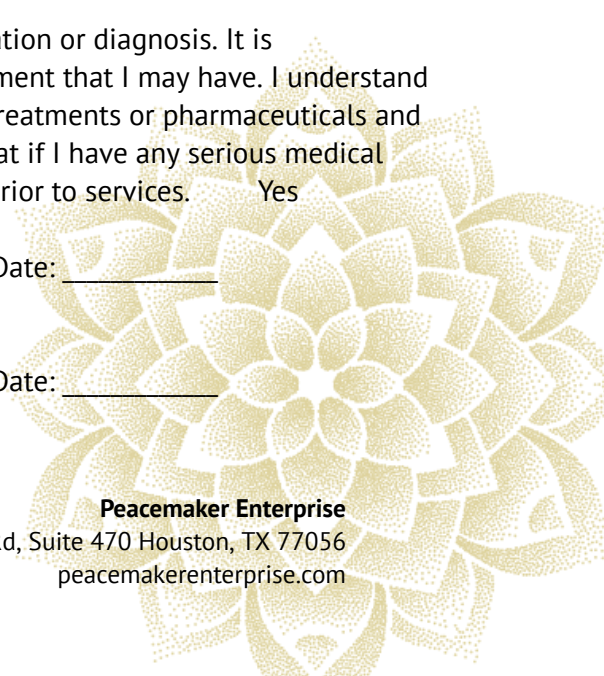
Date: _____

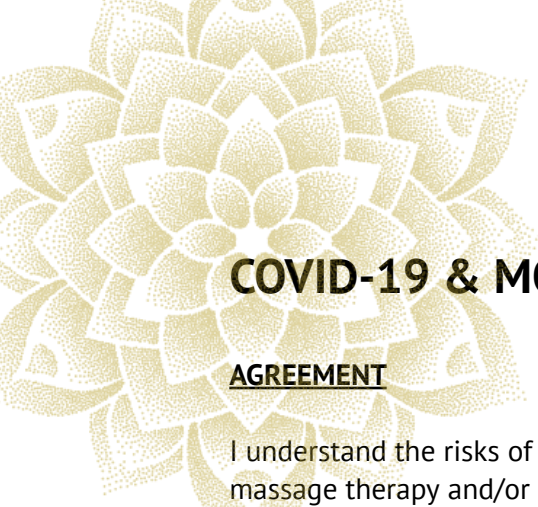
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COVID-19 & MONKEYPOX



AGREEMENT

I understand the risks of COVID-19 and Monkeypox and I knowingly and willingly consent to have massage therapy and/or Reiki treatments performed on my person. I understand that the COVID-19 and Monkey pox viruses can have a long incubation period, during which carriers of the virus may not show symptoms and can still be highly contagious.

I confirm that I am not presenting any of the following symptoms of COVID-19 or Monkeypox listed below: • Fever temperature over 99.6°F degrees • Chills with or without body aches • Shortness of breath • New loss of sense of taste or smell • Unexplained sores on soles of feet • Unusual fatigue • Cough • Sore throat • Swollen lymph nodes • Unexplained rashes.

Please seek immediate medical attention if you are displaying any severe signs of these viruses. I confirm that I have not been in close contact with anyone exhibiting the above COVID-19 or Monkey pox symptoms within the past 21 days.

I further confirm that I am not currently living with anyone who is sick or who is quarantined. To prevent the spread of contagious viruses and to help protect each other, I understand that I will have to follow the massage therapists and/or Reiki practitioner's guidelines.

Signature: _____ Date: _____
Print: _____

Signature: _____ Date: _____
Print: _____





SELF CARE: INFORMATION

1.

TAKING BACK MY LIFE NOW !

PROCESSED FOODS AND SUGARS: MAY AFFECT HOW YOU PHYSICALLY FEEL
CLUTTERED ENVIRONMENTS: MAY AFFECT HOW YOU PHYSICALLY FEEL
DEPRESSION: MAY AFFECT HOW YOU PHYSICALLY FEEL
LACK OF REST: MAY AFFECT HOW YOU PHYSICALLY FEEL
LACK OF WATER: MAY AFFECT HOW YOU PHYSICALLY FEEL
LACK OF EXERCISE: MAY AFFECT HOW YOU PHYSICALLY FEEL
TRAUMA: MAY AFFECT HOW YOU PHYSICALLY FEEL
TOO MANY PEOPLE DON'T LIVE IN THEIR BODIES
MESSAGE HELPS YOU TO COME BACK TO YOUR BODY
MESSAGE CALMS DOWN YOUR NERVOUS SYSTEM

S. Aziz: Registered Massage Therapist: #020625

