



Equine Massage Therapy Intake Form

OWNER INFORMATION

Name: \_\_\_\_\_ Intake Date: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Day Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
E-mail address: \_\_\_\_\_  
Referred by: \_\_\_\_\_

EQUINE INFORMATION

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Breed: \_\_\_\_\_ Mare Gelding Stallion  
Color: \_\_\_\_\_ Discipline: \_\_\_\_\_  
Hands: \_\_\_\_\_ Approximate Weight: \_\_\_\_\_  
Veterinarian/Clinic: \_\_\_\_\_

Massage & Health History

Has equine ever had a professional massage before?  Yes  No Date of Last Massage \_\_\_\_\_  
What are the reasons for equine's visit today? \_\_\_\_\_  
What results do you want from your equine's massage sessions? \_\_\_\_\_

Please describe exercise activities & frequency \_\_\_\_\_  
Is equine under the care of a veterinarian?  Yes  No If yes, please explain: \_\_\_\_\_

Please list any medication, including supplements: \_\_\_\_\_

Please list any recent injuries/accidents/surgeries/illnesses that are affecting equine currently: \_\_\_\_\_

Describe any conditions indicated above, or other conditions that you feel may be important:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Contract for care:*

*I promise to participate fully as a member of my equine's health care team. I will make sound choices regarding my equine's treatment plan based on the information provided by my Massage Therapist and other members of my equine's health care team. I agree to participate in the self-care program that we select. I promise to inform my equine's health care team any time I feel my equine's well-being is threatened or compromised. I expect my Massage Therapist to provide safe and effective treatment.*

**(TURN FORM OVER)**

*Consent for care:*

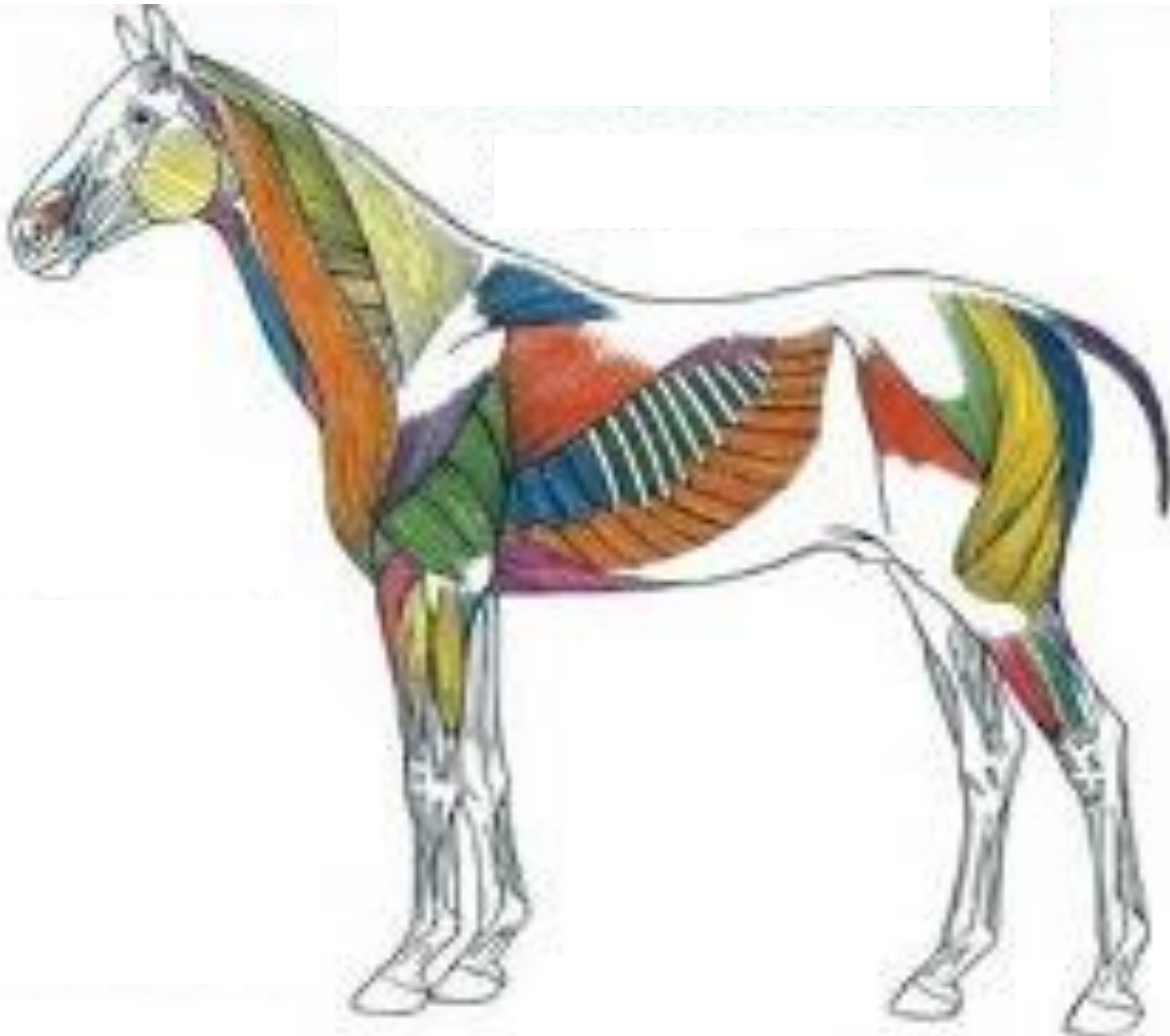
*It is my choice to receive massage therapy for my equine, and I give consent to receive treatment. I understand that Massage Therapists DO NOT diagnose illness, disease or any other physical or mental disorders. Massage therapy is not a substitute for medical examination and/or diagnosis. I affirm that I have stated all my equine's known medical conditions and shall take it upon myself to keep my Massage Therapist updated on my equine's physical/mental health. I also agree there shall be no liability on the practitioner's part should I neglect to do so.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you are unable to keep your appointment, please give 24 hours-notice.

**Text Messages Confirmation** ~ I acknowledge that I give PHD Massage/Bonnie Dittmer to send me text messages to my cellphone for appointment notifications. \_\_\_\_\_

(Client's signature)



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|-------------------------------|------------------------|
| • 1 <sup>st</sup> Visit – 10% | 6 <sup>th</sup> -      |
| • 2 <sup>nd</sup> Visit – 15% | 7 <sup>th</sup> -      |
| • 3 <sup>rd</sup> Visit – 20% | 8 <sup>th</sup> -      |
| • 4 <sup>th</sup> -           | 9 <sup>th</sup> -      |
| • 5 <sup>th</sup> -           | 10 <sup>th</sup> – 50% |