# Divine Healing Zone

*Client Intake Form*

Name (First/Last): ______________________________ Today's Date: ______________

Address: ______________________________ Cell Phone: ______________ DOB: __________

City: ______________ State: _____ Zip Code: _______ Email: ______________________

Emergency Contact: ____________________ Relationship: ______________ Phone: __________

How did you hear about us: ☐ Website ☐ Google ☐ Yahoo ☐ Yelp ☐ Facebook/Instagram

☐ Groupon/LivingSocial ☐ Family/Friend (Name): ________________ ☐ Other: ____________

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## Medical Information

Are you taking ay medications? ☐ YES ☐ NO

If yes, please list name and use: ______________________

______________________________________

Are you currently pregnant? ☐ YES ☐ NO

If yes, how far along? ______________________

Do you suffer from chronic pain? ☐ YES ☐ NO

If yes, please explain: ______________________

______________________________________

Have you had any surgeries? ☐ YES ☐ NO

If yes, please list: ______________________

______________________________________

Do you see a chiropractor? ☐ YES ☐ NO

**Please indicate any of the following that apply to you.**

☐ Cancer ☐ Fibromyalgia
☐ Headaches/Migraines ☐ Stroke
☐ Arthritis ☐ Heart Attack
☐ Diabetes ☐ Kidney Dysfunction
☐ Joint Displacement(s) ☐ Blood Clots
☐ High/Low Blood Pressure ☐ Numbness
☐ Neuropathy ☐ Sprains or Strains

Explain any conditions you have marked above:

______________________________________

______________________________________

______________________________________

______________________________________

## Massage Information

Have you had a professional massage before? ☐ YES ☐ NO

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

Other ______________________________________

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ YES ☐ NO

If yes, please explain: ______________________

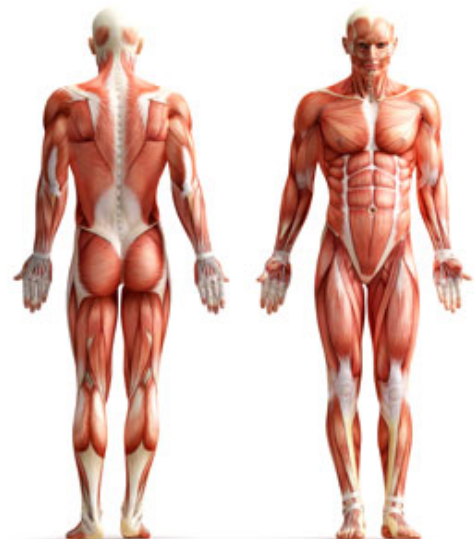
Are there any areas (head, face, feet, etc.) you **DO NOT** want massaged? ☐ YES ☐ NO

If yes, please explain: ______________________

What are your goals from your massage today?

☐ Relaxation ☐ Pain Relieve ☐ Stress Reduction

**Please circle any areas of tension, pain or discomfort.**



## MASSAGE CLIENT WAIVER

It is my choice to receive massage services at **Divine Healing Zone.** I have completed this form to the best of my knowledge. I affirm that I have stated all known medical conditions including all known allergies or prescription drugs or products I am currently using. I agree to update **Divine Healing Zone** of any changes to my medical profile and understand there shall be no liability on the massage therapist part should I fail to do so. I understand that massage therapist does not diagnose illness, disease, or physical or mental disorders, nor do they prescribe medical treatments, pharmaceuticals, or perform spinal manipulations. I acknowledge that these treatments are not a substitute for medical examination or diagnosis, and that it is recommended I see a primary health care provider for that service. If I experience any pain or discomfort during my session I will immediately inform my massage therapist. I give permission to my massage therapist to perform the procedures we have discussed and will hold them and **Divine Healing Zone** harmless from any liability that may result from this treatment. In the event that I may have additional questions or concerns regarding my treatment, I will consult my massage therapist immediately.

I understand that any illicit or sexually suggestive behavior, remarks or advances made by me will result in the immediate termination of the session and I will be liable for payment of the full amount of the scheduled service.

I understand that Divine Healing Zone reserves the right to change pricing without notice.

## CANCELLATION POLICY

I agree to cancel my appointments 24-hours in advance. If I do not cancel or show for my scheduled appointment without giving 24-hour notice, I agree to pay a $30.00 cancellation fee.

________________________________________ ____________________

Client Signature Date

________________________________________ ____________________

Massage Therapist Signature Date

## CONSENT TO TREAT A MINOR FOR MASSAGE THERAPY

By my signature below, I hereby give consent for my minor child (17-year-old and under) to receive massage therapy treatments from the massage therapists at **Divine Healing Zone** as they deem necessary.

________________________________________ ____________________

Client Name (Print) Date

________________________________________ ____________________

Parent/Guardian Signature Date