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: _____

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

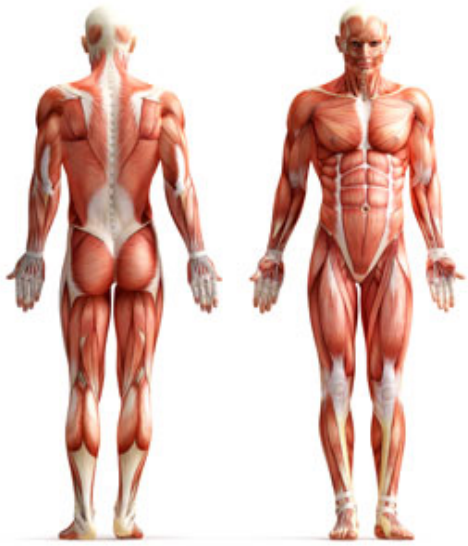
want massaged? ☐ YES ☐ NO

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 ALSO, understand that close contact with people increases the risk of infection from COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage from this facility (DHZ).*

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

Waiver of Liability Related to Coronavirus / COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization (WHO). COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Divine Healing Zone has put in place preventative measures to reduce the spread of COVID-19; however, Divine Healing Zone cannot guarantee that you will not become infected with COVID-19. Further, entering the office could increase your risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 by entering Divine Healing Zone and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at the office may result from the actions, omissions, or negligence of massage therapists, myself or others. I voluntarily agree to assume all the foregoing risks and accept sole responsibility for any injury (including, but not limited to, personal injury, disability, and death) illness, damage, loss, claim, liability, or expense, of any kind, that may experience or incur in connection with my presence at the office.

On my behalf, I hereby release, covenant not to sue, discharge, and hold harmless Divine Healing Zone, its employees, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of Divine Healing Zone, agents, and representatives, whether a COVID-19 infection occurs before, during, or after being in the office.

CLIENT SIGNATURE _____

PRINT NAME OF CLIENT _____

DATE _____