Massage Therapy Client Intake Form

Shannon Browning
SKIN & BODY

General Information

Name | Date of Birth

Address

City | State | Zip Code

Phone # | Email

Occupation

Physician's Name | Physician's Phone #:

Emergency Contact Name | Phone #

Would you like to be added to our email list for specials and discounts? Yes ☐ No ☐

How did you hear about us?

Medical History

Please check all that apply:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bursitis
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic Cough
- ☐ Diabetes
- ☐ Digestive Conditions
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Frequent Colds
- ☐ Headaches/Migraines
- ☐ Hearing Loss
- ☐ Heart Attacks
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ Jaw Pain (TMJ)
- ☐ Low Blood Pressure
- ☐ Lyme Disease
- ☐ Multiple Sclerosis
- ☐ Numbness/Tingling
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Poor Circulation
- ☐ Psychiatric Disorder
- ☐ Rashes
- ☐ Ringing In Ears
- ☐ Sciatica
- ☐ Seizures
- ☐ Sensory Loss/Change
- ☐ Shortness of Breath
- ☐ Sinusitis
- ☐ Smoker
- ☐ Stroke
- ☐ Tendonitis
- ☐ Vertigo/Dizziness
- ☐ Vision Loss
- ☐ Vision Problems
- ☐ Other: _____

How would you rate your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you currently under medical care? Yes ☐ No ☐

Are you or could you be pregnant? Yes ☐ No ☐

Are you currently taking any medications? Yes ☐ No ☐

If yes, please explain:

Do you have any allergies? Yes ☐ No ☐

If yes, please explain:

Do you see a chiropractor? Yes ☐ No ☐

If yes, how often:

Do you suffer from chronic pain? Yes ☐ No ☐

If yes, please explain:

Do you sit for long periods of time? Yes ☐ No ☐

If yes, please explain:

Have you had any major accidents or surgeries? Yes ☐ No ☐

If yes, please explain:

How would you describe your stress level (1 being lowest, 10 being highest):

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Conditions you are currently experiencing today (please select all that apply):

☐ Anxiety ☐ Fatigue ☐ Forgetfulness ☐ Headache

☐ Inflammation ☐ Insomnia ☐ Muscle Cramps ☐ Stress

Additional Information

Have you had a professional massage before? Yes ☐ No ☐

If yes, when:

Do you have difficulty laying on your front, back, or side? Yes ☐ No ☐

If yes, when:

Are you sensitive to touch or pressure on any areas of your body? Yes ☐ No ☐

If yes, explain:

Are there areas that you do not want massaged? Yes ☐ No ☐

If yes, explain:

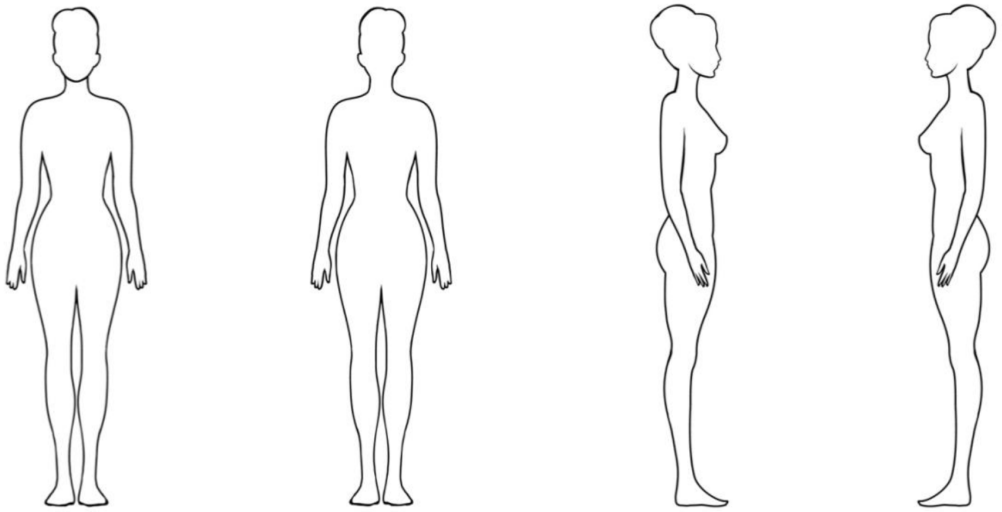
Are you sensitive to fragrances or perfumes?

Do you have sensitive skin?	Yes ☐	No ☐
Do you wear contact lenses?	Yes ☐	No ☐
Do you wear dentures?	Yes ☐	No ☐
Do you wear a hearing aid?	Yes ☐	No ☐
Do you exercise regularly?	Yes ☐	No ☐

What pressure level would you like?

☐ Light ☐ Medium ☐ Firm

Please circle the areas you would like your therapist to focus on:



Front Back Right Left

By signing below, I agree to the following:

I have completed this form to the best of my ability and knowledge. I agree to inform the massage therapist of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the massage therapist of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my massage therapist and the spa for any injury or damages incurred due to any misrepresentation of my health.

Name Printed _____ Signature _____ Date _____

Are you sensitive to fragrances or perfumes?

Do you have sensitive skin?	Yes ☐	No ☐
Do you wear contact lenses?	Yes ☐	No ☐
Do you wear dentures?	Yes ☐	No ☐
Do you wear a hearing aid?	Yes ☐	No ☐
Do you exercise regularly?	Yes ☐	No ☐

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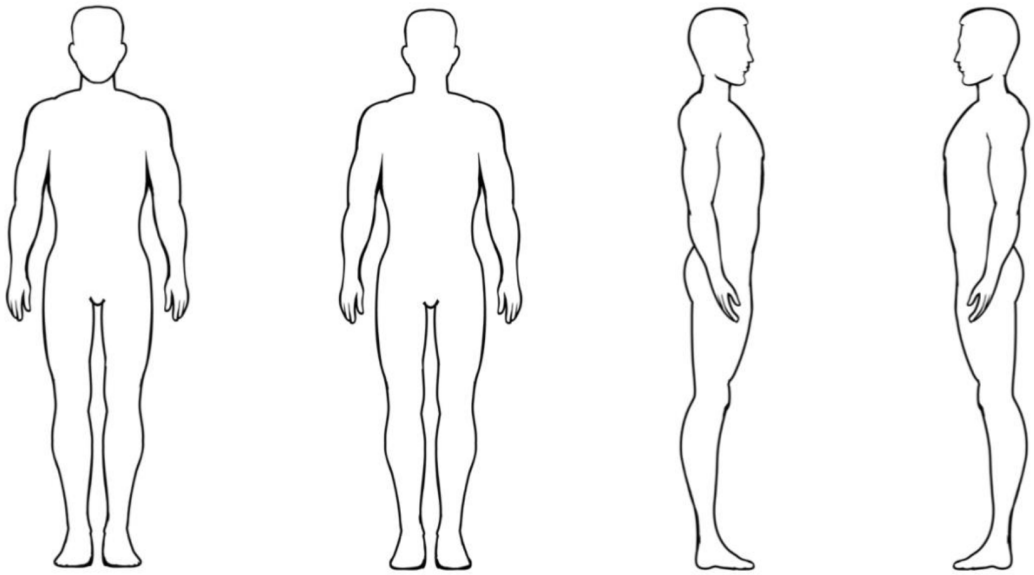

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Name Printed _____ Signature _____ Date _____

Massage Therapy Informed Consent Form

Please take a moment to read and initial the following information:

_____ I understand the benefits and risks of massage and give my consent for massage.
_____ I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.
_____ I understand that there is no implied or stated guarantee of the success of the effectiveness of individual techniques or series of appointments.
_____ If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
_____ I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.
_____ I affirm that I have notified my therapist of all known medical conditions and injuries.
_____ I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.
_____ I understand that massage is entirely therapeutic and non-sexual in nature.
_____ I understand that draping will be used for my privacy and that genitalia and women's breasts will not be exposed or touch at any time.
_____ I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

Name Printed	Signature	Date

Shannon Browning AES, LMT

Massage Therapist Name	Signature	Date

Consent to Treatment of Minor:

By my signature below, I hereby authorize the massage therapist to administer massage or bodywork therapy techniques to my child or dependent as they deem necessary.

Name Printed	Signature	Date

Cancellation Policy

Your appointment is very important. We understand that sometimes schedule adjustments are necessary. Therefore, we respectfully request at least 24 hours' notice prior to your scheduled appointment time for cancellations or rescheduling of appointments. Please notify us by e-mail if your cancellation is outside of our normal business hours or you're unable to reach us by phone. 512-648-0042 or SBSkinBody@gmail.com

ANY APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE WILL RESULT IN A CHARGE EQUAL TO THE AMOUNT OF THE RESERVED SERVICE. . ALL "NO SHOWS" WILL BE CHARGED 100% OF THE RESERVED SERVICE AMOUNT.

We recognize the time of our clients and therapist is valuable and have implemented this policy for this reason. When you miss an appointment with us, we not only lose your business but also the potential business of other clients who could have scheduled an appointment for the same time.

Please remember that it is your responsibility to remember your appointment dates and times in order to prevent any missed appointments which result in a cancellation fee. Not receiving an electronic notification of your appointments from us is not sufficient reason to miss an appointment if the original confirmation notification was received timely.

It is mutually understood that if a cancellation is due to circumstances beyond any of our control, such as power outage, unfortunate incidence, illness, or weather that requires you or us to have to cancel or be closed during regular business hours, we will reschedule your existing appointment and no discount or rescheduling fee will apply.

I have read and understood the cancellation policy and agree to abide by the above conditions.

Name Printed	Signature	Date

Covid-19 Liability Release Form

Due to COVID-19, we are taking extra precautions with each client and have improved our sanitation and disinfecting practices. Please complete the following and sign below.

☐ I confirm that I, nor anyone in my household have any of the following symptoms of COVID-19 listed below, nor have had any of the following symptoms in the past 14 days:

☐ Fever	☐ Body aches
☐ Chills	☐ Headache
☐ Cough	☐ New loss of taste or smell
☐ Shortness of breath	☐ Sore throat
☐ Difficulty breathing	☐ Congestion or runny nose
☐ Fatigue	☐ Nausea or vomiting
☐ Muscle aches	☐ Diarrhea

☐ To the best of my knowledge, neither I nor anyone in my household has been in contact with anyone who has tested positive for COVID-19._____(initial)

☐ I verify that neither I nor anyone in my household has traveled outside of _____ in the past 14 days._____(initial)

☐ I understand that the CDC recommends social distancing of at least 6 feet, and this is not possible with the service I am receiving today._____(initial)

By signing below I knowingly and willingly consent to release any and all liability for the unintentional exposure or harm due to COVID-19.

_____	_____	_____
Name Printed	Signature	Date