Cypris Bodywork & Wellness

100 Cherokee Blvd. Suite 308
Chattanooga, TN 37405
(336) 408-4380

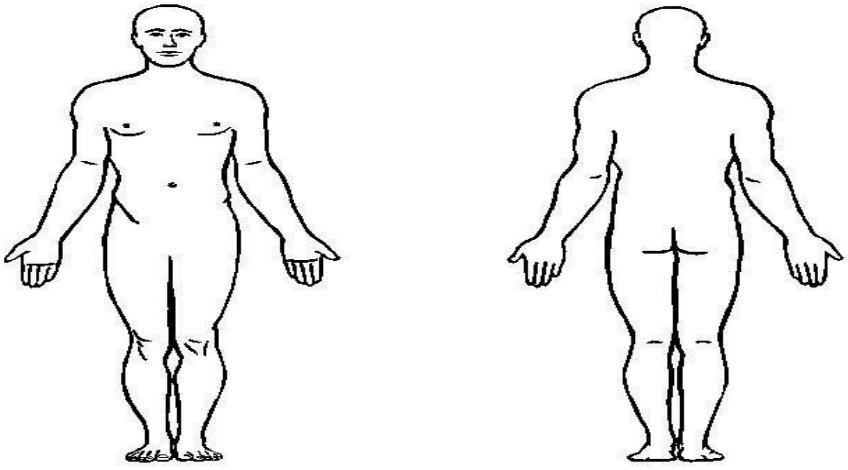
Client Intake Form

Name (First, Last) _____ Preferred Pronouns_____
Phone (day)_____ Phone (Night)_____ Email_____
Address City/State/Zip_____
Date of Birth_____ Height_____ Wieght_____Occupation_____
What Brings You In Today?_____
_____

1. Have you had a professional massage before?_____
   If yes, how often do you receive massage therapy?_____
2. Do you have any difficulty lying on your front, back, or side?
   If yes, please explain_____
3. Do you have any sensitivity to oils, lotions, ointments or smells?_____
   If yes, please explain_____
4. Do you have sensitive skin?_____
5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( ) ?
6. Do you sit for long hours at a workstation ( ) computer ( ) driving ( )?
7. Do you perform any repetitive movement in your work, sports, or hobby?_____
   If yes, please describe_____
8. What place in your body do you normally hold stress?_____
9. What goals do you have for this massage session?_____

_____

Circle any specific areas you would like the massage therapist to concentrate on during the session:



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Medical History

Do you have a history of any of the following conditions? Please check those that apply:

	Tumor Removal		Cancer		Varicose Veins		Blood Clots
	Bruise Easily		Heart Disease		Stroke		High/Low Blood Pressure
	Chronic Pain		MS		Fibromyalgia		Inflammatory Disease
	Osteoporosis		Arthritis		Gout		Bone/Joint Disease
	Jaw Pain		Headaches		Migraines		Respiratory Disease
	Depression		Anxiety		Insomnia		Urological Issues
	Diabetes		Sprain/Strain		Surgery		Pregnancy Current/Past
	IBS		Crohn's / UC		Neuropathy		Gynecology Issues

Medical History Details

Please describe any condition you have experienced that was not listed above as well as describing any condition you checked yes:

_____
_____
_____
_____
_____
_____

Are you currently taking any medications?
If yes, please list here:_____
_____
_____
_____

Do you have any allergies? If yes, please list_____
_____
_____

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Client Agreement

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Signature_____ Date_____

Contract For Care

I will participate fully as a member of my healthcare team. I will make sound choices regarding my sessions' plan based upon the information provided by my massage therapist. I agree to participate in my own self-care programs and adhere to the plan we select. I agree to communicate with my practitioner any time I feel my well-being is being compromised. I expect my practitioner to provide safe and effective treatment to the best of his or her skills and knowledge.

Signature_____ Date_____

Cancellation Policy

I acknowledge that a 24 hour notice is required for cancellation of appointments. I agree to be charged half of my visit cost if I cancel 4-24 hours before a scheduled appointment. I agree to be charged the full visit cost if I miss a scheduled appointment or cancel a scheduled appointment less than 4 hours before I am scheduled. I acknowledge that my appointment starts at the time it is scheduled, and ends promptly at the agreed upon appointment duration.

Signature_____ Date_____

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