CONFIDENTIAL CLIENT INTAKE FORM

Full Name:____

Adress:____

City:______________________________ **State:**__________ **Zip:**______________

Occupation:____

MEDICAL HISTORY

- ☐ Arthritis
- ☐ Circulatory Problems
- ☐ Sleep Problems
- ☐ Diabetes
- ☐ Irregular Digestion
- ☐ Hypertension
- ☐ Varicose Veins
- ☐ Claustrophobia
- ☐ Headaches
- ☐ Herpes Simplex Virus
- ☐ Eye Infection/Disorder
- ☐ Heart Disease
- ☐ Eczema Psoriasis
- ☐ Keloid/Hypertrophic Scars
- ☐ MRSA
- ☐ Chronic Pain
- ☐ Epilepsy
- ☐ Sciatica
- ☐ Osteoporosis
- ☐ Hyper/Hypo Thyroid

Other: ______________________________

Have you ever been diagnosed with cancer? Yes No
(If yes, we currently do not provide oncology massages.)

Are you currently pregnant/nursing or trying to become pregnant? Yes No If pregnant, How many weeks?______
(If yes, please complete our **Prenatal Intake Form**)

Are there any other medical conditions or concerns we need to know about? Yes No
Please Explain:____

GENERAL HEALTH

Current Medications:

____

____

____

____

____

____

____

____

Rate your level of stress Low 1 2 3 4 5 High

Skin Sensitivities / General Allergies? Yes No

Do you smoke? Yes No
If yes, How many cigarettes per day?_________

Do you have: Metal Implants? Yes No

A Pace Maker? Yes No

Body Piercings? Yes No

Please list any accidents or surgeries in the last 12 months:

(If you have had surgery within the past 12 months please complete our Post Surgery Massage Consent Form)

Are you experiencing tingling or numbness in a specific area? Please explain:

Preferred method of communication:

☐ Phone: (________) _________ - __________ ☐ Text

☐ Email: ____

DOB (MM/DD/YY)_________/__________/__________

Emergency Contact
Name: ____
Relationship:____
Phone:(_________) __________ - ____________

How did you hear about us? Or Name of person who referred you
____

Goal for this session:

- ☐ Relaxation
- ☐ Escape
- ☐ Headache
- ☐ Stress Reduction
- ☐ Pain Relief
- ☐ Health / Wellness

MASSAGE PREFERENCES
*Face and scalp massage upon request

Have you ever experienced a professional massage before?
How recently?

If yes, what did you like about it?

What didn't you like about it?

Would you like focus on specific areas?

Are there any areas that should be avoided?

Preferred Pressure:
Light -------- Med -------- Firm -------- Deep

This questionnaire gives us information that will enable us to provide you exceptional services and treatments safely and effectively. All information is completely confidential, and vital for your protection as well as ours. Thank you for your cooperation.

Please complete the back of this form

ZENSSAGE
MASSAGE THERAPY

Policies

_____ No - Show / Cancellation / Early Termination

Credit card required to hold appointment. If I am unable to make a scheduled appointment. I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case i will call ASAP to reschedule my appointment.

If I miss a scheduled appointment without giving 24 hour notice. I agree to pay 100% of the reserved appointment.

If I have missed more than 3 appointments, I understand that I will need to prepay the full amount prior to my future appointments.

If I terminate the session early, for any reason, I am responsible for the 100% of the reserved appointment time.

_____ Consent to Treatment

It is my choice to receive treatment, because massage/bodywork should not be performed under certain medical conditions. I affirm that I have stated all my known medical conditions, or answered all questions asked of me honestly. I will update Zenssage Massage Therapy of any changes to my health status. I understand that massage therapists DO NOT diagnose illness, disease, or physical or mental disorders, nor do they prescribe medical treatments, pharmaceuticals, or performed spinal manipulations or skeletal adjustments and that nothing said in the course of the session given should be construed as such. 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 the session, I will IMMEDIATELY inform the massage therapist so that the service may be adjusted to my level of comfort or discontinued. I could experience varying degrees of redness, and soreness after a massage.

I further understand that I am paying for a treatment and not a result and that there will be no returns, refunds, or exchanges.

_____ Sexual Misconduct

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 scheduled service and any damaged supplies. Further, I understand that Zenssage Massage Therapy reserves the right to refuse to administer services at their sole discretion.

Draping will be maintained throughout the session. At any point a guest or massage therapist is uncomfortable, they may request to stop the service, and YOU, the guest are responsible for 100% of the reserved appointment time. The therapist WILL NOT massage female breast tissue nor genitalia.

CONSENT TO TREATMENT OF MINOR

By my signature below, i authorize Zennsage Massage Therapy to administer massage techniques to my minor child or dependent as they deem necessary or proper.

____
Signature Date

____
Print Name

____
Signature Date

____
_Therapist Signature Date

COVID-19 LIABILITY WAIVER

To prevent the spread of COVID-19 and reduce the potential risk of exposure to our workforce and guests, we are conducting a simple screening questionnaire. Your participation is important and required to help us take precautionary meeasures to protect you and everyone in this building. Thank you for your time, consideration and truthful responses.

_____ I have not cared for someone diagnosed with COVID-19.

_____ I have not experienced any cold or flu-like symptoms within 14 days.

_____ I agree to wear a mask at all times during my appointment.

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 mere presence within this establishment 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 may result from the actions, omissions, or negligence of myself and others, including but not limited to, employees, volunteers, and program participants and their families.

I hereby release Zenssage Massage Therapy from any and all claims arising from or in connection with any direct COVID-19 impact while visiting.

I Agree to all of the above.

Print Name

Signature Date

_Therapist Signature

Date