

# Massage Therapy Client Health Intake Form

## Information Agreement

### CONTACT INFORMATION

To Be Completed By Client

Name:	Phone Number:		<input type="checkbox"/> OK to leave message
Address:	City/State:	Zip:	
Email Address:	Date of Birth:		
<input type="checkbox"/> I would like to receive Notifications from <input type="checkbox"/> Email <input type="checkbox"/> Text Message			

### CY Bodywork Policies

Please review and check each. (Please ask if you have any questions, concerns or need additional information):

- ☐ I may undress to my comfort level. I will be properly draped, meaning covered by the sheet and/ or blanked at all times. The therapist will only uncover the part of the body that is being worked on during the massage session.
- ☐ As further explained below, the therapist reserves the right to terminate the session at any time in the event of any sort of inappropriate behavior from me.
- ☐ CY Bodywork's therapists do not perform breast massage.
- ☐ If I am under the age of 18, my parents or guardian must sign a Minor Consent Form and must be present in the room during the massage session.
- ☐ As further explained below, I understand that I may end the session at any time if I feel uncomfortable for any reason.

### TERMS & CONDITIONS

Please review and sign at the bottom of the page. (Please ask if you have any questions, concerns or need additional information )

**BY SIGNING BELOW, I ACKNOWLEDGE AND AGREE TO ALL OF THE FOLLOWING TERMS:** The Studio identified below is independently owned and operated by the Operator. CY Bodywork LLC ("CYB"), does not own or operate the Studio and is not contractually or otherwise liable to any individual who receives services at the Studio. I acknowledge and understand that the Studio's massage therapists and other personnel are employees of Operator and are not employed by CYB. Massage and bodywork therapy is not a replacement for medical care and no medical diagnosis will be made. Because massage and bodywork therapy may be contraindicated due to certain medical conditions, I affirm that I have informed the Studio of all known medical conditions and will keep the Studio updated as to any changes in my condition going forward. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or manipulations, draping or environment may be adjusted to my level of comfort.

**ASSUMPTION OF RISK, RELEASE, WAIVER OF LIABILITY, INDEMNIFICATION, AND MEDIATION:** By signing below, I hereby waive all claims, assume all risks and liability, and release, indemnify, and agree to defend Operator, ETM, their subsidiaries and affiliates and their respective owners, officers, directors, employees, representatives, successors, and assigns (each a "Released Party"), from liability for any injury, claim, cause of action, suit, demand, and damages (each a "Claim") (including, without limitation, personal injury, economic loss, and punitive or consequential damages) arising in whole or in part out of my receipt of services at the Studio, including any Claims based on any Released Party's negligence, breach of any contract and/or express or implied warranty, or any and all violation(s) of applicable federal law or law of the state in which the Studio is located, whether known or unknown as of the date hereof. If any damages are nevertheless enforced against any Released Party, such damages shall exclude punitive or consequential damages and shall be limited to the total amount paid to Operator in the twelve (12) months preceding the Claim. As a precondition to initiating any legal proceeding against any Released Party, I agree to engage in mediation of any Claims with the Operator. If any terms of this provision are held to be invalid, illegal, or unenforceable, all other terms shall remain in full force and effect.

**COMMUNICATIONS POLICY:** Operator may occasionally send promotional opportunities and marketing materials via email, phone calls, text messages, faxes, and other electronic messages. If you do not wish to have your contact information used to promote CY Bodywork® products or services, you can opt-out of receiving such communications by checking the relevant box below. If the Operator has sent you a promotional email, you may send a return email asking to be omitted from future email communications or unsubscribe by following the link found at the bottom of the e-mail communication. Subject to applicable law, this opt-out does not apply to appointment reminders and communications about service purchases, billing information, late charges, product service experience or other transactions.

☐ I do not wish to receive promotional opportunities.

**Name of Studio: CY Bodywork**

**("Operator")**

Signature:	I acknowledge I have received notice of (or have been given the opportunity to review) Operator's privacy and security policy.  _____ (initiate here)	Date:	MT Initials:
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# Massage Therapy Client Health Intake Form

## Information Agreement

### HEALTH HISTORY

Please check all current/ past conditions that apply:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> blood clots         | <input type="checkbox"/> diabetes                | <input type="checkbox"/> active cancer  | <input type="checkbox"/> wear contact lenses              |
| <input type="checkbox"/> stroke/heart attack | <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> osteoporosis   | <input type="checkbox"/> jaw clenching/teeth grinding     |
| <input type="checkbox"/> muscle / joint pain | <input type="checkbox"/> bruise easily           | <input type="checkbox"/> varicose veins | <input type="checkbox"/> numbness/tingling, if so, where: |
| <input type="checkbox"/> headaches           | <input type="checkbox"/> seizures                | <input type="checkbox"/> fibromyalgia   | _____   |

Please list any other medical conditions and/or any medications you are currently taking:

Please list any accidents, injuries and/or surgeries in the last two years and include date of occurrence:

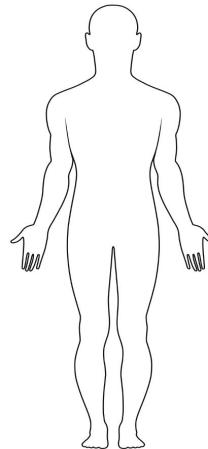
Are you pregnant? ☐ Yes ☐ No If yes, how many weeks: \_\_\_\_\_ Postpartum 6 months or less? ☐ Yes ☐ No DOB: \_\_\_\_\_

Do you have any allergies and/or skin sensitivities? ☐ Yes ☐ No If yes, please list:

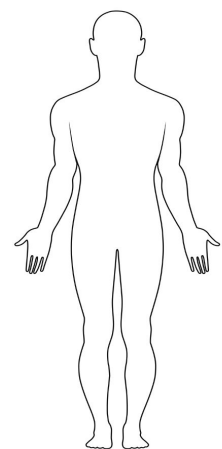
In the chart below, please indicate the parts of your body that will be massaged or the areas of your body that will be avoided during the session

- **Indicate yes or no and initial to consent for each of the areas of the body.**
  - Scalp ☐ Yes ☐ No
  - \_\_\_\_\_ Pectoral Muscle ☐ Yes ☐ No
  - \_\_\_\_\_ Abdominal Muscle ☐ Yes ☐ No
  - \_\_\_\_\_ Glutes ☐ Yes ☐ No
  - \_\_\_\_\_ Feet ☐ Yes ☐ No
- **Place an X on any other areas to be avoided.**
- **Place a CIRCLE around areas that need extra attention.**

**Front**



**Back**



By signing this form, I consent to its policies, the selected techniques, and the selected areas of my body to be massaged as defined by the therapist. I further acknowledge and agree that I will notify the Studio if I wish to update which areas of my body I consent to have massages during sessions, which techniques are to be used, or have changes in my health history.

Signature:

Printed Name:

Date:

### SESSION CONSULTATION

To Be Completed By Massage Therapist.

LMT Signature:

Date: