

Elevated Wellness Massage & Spa

CLIENT INTAKE FORM

Name _____ Date _____

Occupation _____ Birthday _____ Female Male NB

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Emergency Contact _____ Emergency Contact Phone # _____

How did you learn about us? _____

Would you like to be added to our email list for new and exciting offers? Yes No

MEDICAL HISTORY

Do you have any of the following conditions? If yes, please select them:

- | | | |
|--|---|--|
| <input type="checkbox"/> Arthritis/ joint disorder | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Recent accident/ injury |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Recent fracture |
| <input type="checkbox"/> Back/ neck problems | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Seborrhea |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches/ migraines | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Carpal tunnel syndrome | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Skin disease/ lesions |
| <input type="checkbox"/> Circulatory disorder | <input type="checkbox"/> High/ low blood pressure | <input type="checkbox"/> Sprains/ strains |
| <input type="checkbox"/> Contagious skin condition | <input type="checkbox"/> Immune disorders | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Decreased sensation | <input type="checkbox"/> Keloid scarring | <input type="checkbox"/> Tennis elbow |
| <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> Open sores or wounds | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Varicose veins |

Any other illness/ condition: _____

Any recent surgery, including plastic surgery? _____

Are you currently taking any medications? _____

Are you currently being treated by a medical professional? _____

Massage Therapy

CLIENT INTAKE FORM

Have you had a professional massage before?

Yes No

Do you have any difficulty lying on your front, back, or side?

Yes No

Do you have any allergies to oils, lotions, or ointments?

Yes No

Do you have sensitive skin?

Yes No

Are there any areas (feet, face, abdomen) you do not want massaged? _____

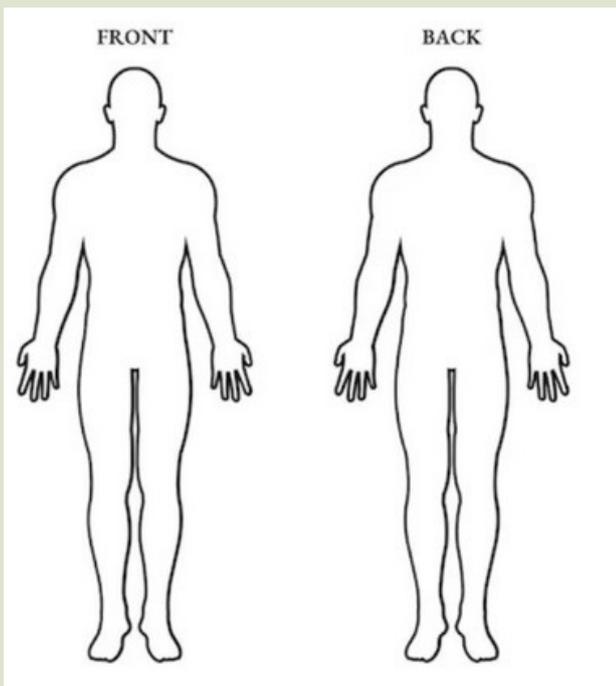
What type of massage are you seeking?

Relaxation Therapeutic/deep tissue

What pressure do you prefer?

Light Medium Deep

Please circle any areas of discomfort:



What are your goals for this treatment session?

I agree that the above information is accurate and to the best of my knowledge and give permission to be massaged today. I agree to inform my therapist if I experience any pain or discomfort during the session. I understand that massage therapy is for stress reduction, relief from muscular tension or spasm, or for increasing circulation. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment nor perform spinal manipulations. I will inform the therapist of my current condition and any change in my physical health at the time of each visit and I understand there shall be no liability on the practitioner's part or Elevated Wellness Massage & Spa should I fail to do so. I hereby give my consent and authorization voluntarily and release Elevated Wellness Massage & Spa from any claims, implied or stated that, I have or may have in the future with this treatment/service, regardless of result. I am stating that the treatments/ service and precautions above have been explained to me in detail and that I fully understand.

Client Name (Printed) _____

Date: _____

Client Name (Signature) _____

Initial this box that you positively identify as the name printed & sign

Yoga Services

CLIENT INTAKE FORM

YOGA HISTORY:

Have you practiced yoga before? Yes No

Any medical conditions, injuries, or limitations affecting movement? Yes No

If yes, please explain: _____

Experience dizziness or balance issues during movement? Yes No

If yes, please explain: _____

Any movements or positions you prefer to avoid? Yes No

If yes, please explain: _____

Any specific areas of concern for your session? (Injuries, tightness etc.) Yes No

If yes, please explain: _____

What goals and benefits are you seeking from your yoga practice?

- | | |
|---|--|
| <input type="checkbox"/> Strength Training | <input type="checkbox"/> Breathe Work |
| <input type="checkbox"/> Flexibility | <input type="checkbox"/> Meditation |
| <input type="checkbox"/> Balance | <input type="checkbox"/> Yoga Philosophy |
| <input type="checkbox"/> Increase well-being | <input type="checkbox"/> Improve Fitness |
| <input type="checkbox"/> Stress relief | |
| <input type="checkbox"/> Address Health Concern | |
| <input type="checkbox"/> Alternative therapy | |
| <input type="checkbox"/> Posture | |

By signing below, I acknowledge that participating in yoga classes or sessions at Elevated Wellness Massage and Spa involves physical activity that may result in injury. I understand that it is my responsibility to practice safely, within my limits, and to inform the instructor of any medical conditions, injuries, or concerns. I certify that I am in good health or have received medical clearance to participate. I understand that Elevated Wellness Massage and Spa and its yoga practitioner(s) are not liable for any injury, loss, or other damages that may occur as a result of my participation. I voluntarily assume all risks associated with yoga practice and release, waive, and hold harmless Elevated Wellness Massage and Spa and its staff from any claims or liability arising from my participation.

Client Name (Printed) _____

Date: _____

Client Name (Signature) _____

Initial this box that you positively identify as the name printed & sign

Elevated Wellness Massage & Spa

POLICY NOTIFICATION

CANCELLATION & NO SHOW

If it is necessary to change your appointment, we request you do so a minimum of 3 hours in advance for an individual appointment or 24 hours in advance for a party of 2 people or more. This time is especially reserved just for you and if the appointment is not cancelled then we are not able to offer the time to another guest. Regretfully, if we do not receive adequate notice of cancellation, a cancellation or no-show fee will be charged to the card on file for each service scheduled. Late cancellations will be charged \$25 and No-Shows will be charged the full-service amount. If there is no card on file, these fees will be collected before scheduling another appointment.

MESSAGE TERMINATION

Only professional massage and bodywork services for relaxation or therapeutic purposes are offered at this spa. Services will be terminated immediately in the event of inappropriate conduct of any kind. This includes harassment, threatening speech or behavior, sexual advances or requests, or disrespectful actions or language. A session will not be conducted if the client is under the influence of drugs or alcohol. If the session is terminated for any of these reasons full payment for the scheduled session is still required.

LATE ARRIVAL

All scheduled appointments will end at the scheduled ending time in order for us to stay on schedule. Clients who arrive late to their scheduled appointment will be charged for the full session and will not receive a time extension. For your first appointment, please arrive 15 minutes prior to your scheduled appointment time to allow time to complete the client intake form. For all other appointments, please arrive 5-10 minutes before your scheduled appointment time to allow time to use the restroom and enjoy a relaxed and unhurried experience.

DRAPING

Clients will be appropriately draped with a sheet and/or towel at all times during their session. Only areas of the body that are currently being treated will be exposed. The breasts and genital areas will always remain draped and are never massaged.

Signing below indicates that you have read, fully understand and will abide by the massage policies as listed above.

Client Name (Printed)

Client Name (Signature)

Date: