



Client Intake Form

Client Name: _____ Date: _____

Address: _____

Phone: _____ Home Cell Work (circle one)

DOB: _____ Gender: _____

Email: _____

Referred By: _____

Emergency Contact: _____ Phone: _____

Reason for Visit Today: _____

Have you received professional massage/bodywork before? Yes No

If Yes, what kinds? _____

What are your goals/expected outcomes for today's visit?

List and prioritize your current symptoms or issues: _____

List any medications you currently take and what they're treating:

List any herbal supplements you currently take:

Any Allergies or hypersensitivities? _____

List any major accidents, injuries or previous surgeries (include dates)

List any serious medical conditions you are currently being treated for:

Any contagious skin conditions currently? Yes No if yes, explain _____

Please circle any of the following conditions that you may be experiencing at this time or have previously:

Headaches, migraines

Muscle, Joint Pain

Blood Clots

Dizziness

Swelling

Diabetes

High Blood Pressure

Varicose Veins

Numbness

Low Blood Pressure

Epilepsy, Seizures

Kidney Disease

High amounts of stress

Osteoarthritis

Neurological Conditions

Fatigue

Rheumatoid arthritis

Asthma, Shortness of breath

Depression, Anxiety

Digestive Conditions

Heart Attack, Stroke

Bruise Easily

Cancer

Autoimmune Disorder

Something that is not listed above that you feel is important to know: _____

Please be advised of the policies for this office. Your signature below signifies acceptance of these policies.

Cancellation and Rescheduling- A 24-hour notice is required for rescheduling and cancelling an appointment. Failure to do so will result in a fee if the time slot cannot be filled. Payment is due before your next appointment.

Tardiness- Appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please be on time to your appointment.

Sickness- Massage/bodywork is not recommended for infectious or contagious illness. Please cancel your appointment as soon as you become ill. This includes having a fever. If you fall ill within the 24-hour window, the cancellation fee will be waived.

Consent for Treatment- If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also 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. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Parent or Guardian Signature if client is a minor: _____

COVID-19 Information & Liability Waiver

Client Name: _____ Date: _____

COVID-19 Information

1. Have you had a fever in the last 24 hours of 100°F or above? Yes No
2. Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath? Yes No
3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes No

Consent for Treatment

I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19.

By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time. I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner.

Client Signature: _____

Parent or Guardian Signature (in case of a minor): _____