Massage Client Intake Form

PLEASE CHECK ANY CONDITIONS THAT APPLY TO YOU:

( ) BRUISES EASILY

( ) ALLERGIES/SENSATIVITIES, PLEASE EXPLAIN: _____

( ) DEEP VEIN THROMBOSIS/BLOOD CLOTS

( ) OSTEOPOROSIS

( ) ARTIFICIAL JOINT

( ) PREGNANCY, HOW MANY MONTHS: _____

I HAVE HAD A MASSAGE BEFORE: YES NO

MASSAGE PRESSURE PREFERRED: LIGHT MEDIUM FIRM NOT SURE

IS THERE ANYTHING ABOUT YOUR HEALTH HISTORY THAT YOU THINK WOULD BE USEFUL FOR THE MASSAGE THERAPIST TO KNOW?

_____

_____

I, _____ (PRINT NAME) UNDERSTAND THAT THE MASSAGE I RECEIVE IS PROVIDED FOR THE BASIC PURPOSE OF RELAXATION AND RELIEF OF MUSCULAR TENSION. I WILL BE EXPECTED TO MAINTAIN COMMUNICATION WITH THE MASSAGE THERAPIST DURING THE MASSAGE REGARDING THE LEVEL OF PRESSURE USED SO THAT IT MAY BE ADJUSTED TO MY LEVEL OF COMFORT. I FURTHER UNDERSTAND THAT MASSAGE 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 PHYSICAL OR MENTAL MEDICAL CONDITIONS. I AFFIRM THAT I HAVE STATED ALL MY KNOWN MEDICAL CONDITIONS AND ANSWERED ALL QUESTIONS CORRECTLY & HONESTLY. I AGREE TO KEEP THE THERAPIST UPDATED AS TO ANY CHANGES IN MY MEDICAL PROFILE. I UNDERSTAND THAT THERE SHOULD BE NO LIABILITY ON THE THERAPIST'S PART OR JONES FAMILY CHIROPRACTIC SHOULD I FAIL TO ADHERE TO THESE STIPULATIONS.

CANCELLATION POLICY

BECAUSE YOUR MASSAGE TIME IS SCHEDULED ONLY FOR YOU, WE DO REQUIRE 24 HOURS NOTICE TO CANCEL YOUR APPOINTMENT. IN CASES WHERE 24 HOURS IS NOT PROVIDED, 50% OF YOUR SCHEDULED SERVICE WILL BE CHARGED TO YOU BEFORE YOUR NEXT APPOINTMENT.

DATE: _____ SIGNATURE: _____