

ATLANTA BODY RETREAT

Therapeutic Massage • Neuromuscular Therapy • Manual Lymphatic Drainage

Client Health History & Intake Form

Please complete every section as fully as you can. Your information is confidential and used only to keep your care safe and effective.

PERSONAL INFORMATION

Name: _____ Date of birth: _____ Date: _____
Address: _____ City / State / Zip: _____
Phone (day): _____ (evening): _____ Email: _____
Occupation: _____ Employer: _____
Emergency contact: _____ Relationship: _____ Phone: _____
Primary physician: _____ How did you hear about us? _____

CURRENT HEALTH & MEDICAL CARE

Are you currently under a doctor's or other healthcare provider's care? ☐ Yes ☐ No

If yes, for what condition(s)? _____

Provider name / specialty: _____

Medications, supplements & vitamins (please include dose and what each is for)

Do you have any allergies or sensitivities (oils, lotions, latex, scents, adhesives)? ☐ Yes ☐ No

Please explain: _____

Are you currently pregnant? ☐ Yes ☐ No

If yes, how far along? _____ Any high-risk factors? _____

Do you suffer from chronic pain? ☐ Yes ☐ No

Where / please explain: _____

What makes it better? _____

What makes it worse? _____

Have you had any orthopedic injuries, accidents or whiplash? ☐ Yes ☐ No

If yes, please list (include dates): _____

Swelling, energy & post-viral health

Have you ever experienced chronic or recurring swelling (hands, feet, legs, face or elsewhere)? ☐ Yes ☐ No

If yes, where, how long, and what helps? _____

Do you experience chronic or ongoing fatigue? ☐ Yes ☐ No

If yes, how long and how would you describe it? _____

Have you been diagnosed with Long COVID (long-haul COVID / post-COVID condition)? ☐ Yes ☐ No

If yes, approximate date of illness and current symptoms: _____

Previous surgeries

Have you had any surgeries? ☐ Yes ☐ No

Date (approx.)	Type of surgery	Area of body / notes or complications

Please check any of the following that apply to you

- | | | |
|--|---|---|
| ☐ Cancer (current or past) | ☐ Stroke | ☐ Autoimmune condition |
| ☐ Headaches / Migraines | ☐ Heart attack / heart condition | ☐ Thyroid disorder |
| ☐ Arthritis | ☐ Kidney dysfunction | ☐ Osteoporosis |
| ☐ Diabetes | ☐ Blood clots / DVT | ☐ Varicose veins |
| ☐ Joint replacement(s) | ☐ Numbness / tingling | ☐ Fever / contagious illness |
| ☐ High / Low blood pressure | ☐ Sprains or strains | ☐ Recent injury or surgery |
| ☐ Neuropathy | ☐ Lymphedema | ☐ Anxiety / depression |
| ☐ Fibromyalgia | ☐ Lymph node removal | ☐ Other: _____ |

Please explain any conditions you marked above: _____

SKIN & FOOT HEALTH

Please check any skin or foot conditions you are aware of:

- | | | |
|--|---|--|
| ☐ Warts / plantar warts | ☐ Toenail fungus | ☐ Eczema / psoriasis |
| ☐ Bunions | ☐ Calluses / corns | ☐ Rashes / hives |
| ☐ Athlete's foot | ☐ Open sores, cuts or wounds | ☐ Other skin condition: _____ |

Please explain (location, how long, treated?): _____

MESSAGE INFORMATION & PREFERENCES

Have you had professional massage or bodywork before? ☐ Yes ☐ No

What are you seeking today? (check all that apply)

- | | | | |
|---|--|--|--|
| ☐ Relaxation | ☐ Therapeutic / Deep Tissue | ☐ Neuromuscular Therapy (NMT) | ☐ Manual Lymphatic Drainage (MLD) |
| ☐ Instrument-assisted / cupping ☐ Not sure – please recommend | | | |

Other: _____

Preferred pressure: ☐ Light ☐ Medium ☐ Deep ☐ Varies by area

Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ Yes ☐ No

Please explain: _____

What did you NOT like about previous massage or bodywork sessions? (check all that apply)

- | | | | | |
|---|--|--|---|---|
| ☐ Pressure too light | ☐ Pressure too firm | ☐ Too much talking | ☐ Too little communication | ☐ Music / noise |
| ☐ Room temperature | ☐ Scents / oils | ☐ Draping / modesty | ☐ Felt rushed | ☐ Soreness afterward |

Other / details: _____

What are your goals for your treatment sessions? _____

Are you interested in learning more about Manual Lymphatic Drainage (MLD)? ☐ Yes ☐ No ☐ Maybe

PLEASE READ: ALCOHOL, PAYMENT & POLICIES

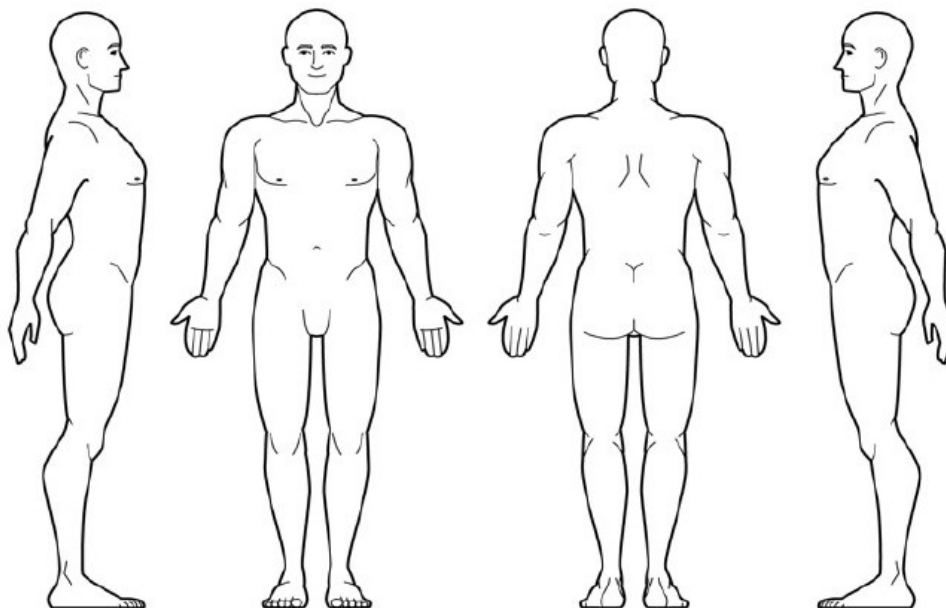
Alcohol & detoxification notice. If you have consumed alcohol within the last few days, please let your therapist know. Massage and lymphatic work increase circulation and fluid movement, and your body may begin to detoxify more quickly. Some clients experience temporary flu-like symptoms (headache, nausea, chills, body aches or fatigue) when this happens. Drinking plenty of water before and after your session is strongly encouraged.

Payment. Payment is due at the time of service. Payments made by any type of credit or debit card will incur a 4.5% processing fee.

Client initials acknowledging the alcohol notice and payment policy: _____

AREAS OF DISCOMFORT

Please circle or mark any areas where you feel pain, tension, swelling or discomfort.



INFORMED CONSENT & CLIENT AGREEMENT

I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of this information changes at any time. I understand that massage therapy and bodywork are not a substitute for medical care, that my therapist does not diagnose illness or prescribe medication, and that I should consult my physician about any medical condition. I understand I may ask questions, request a change in pressure or technique, or stop the session at any time. I consent to the treatment described and understand that results vary and no outcome is guaranteed. I understand that some techniques (including neuromuscular therapy, instrument-assisted work and cupping) may cause temporary soreness, redness or bruising. My information will be kept confidential and shared only with my consent or as required by law.

RELEASE OF LIABILITY & AGREEMENT TO BINDING ARBITRATION

1. Release of liability. To the fullest extent permitted by law, I voluntarily release, waive and discharge Atlanta Body Retreat, Sloane Warren, and each of its owners, employees, contractors, agents, successors and assigns (the "Released Parties") from any and all claims, demands and causes of action arising out of or related to my services, including any injury, soreness, bruising or adverse reaction, except for claims arising from the gross negligence or willful misconduct of a Released Party. I accept the known risks of massage and bodywork and confirm that I have disclosed my relevant health history.

2. Binding arbitration. Any dispute, claim or controversy between me and any Released Party arising out of or relating to my services, this form or my relationship with Atlanta Body Retreat will be resolved exclusively by final and binding arbitration in the State of Georgia, administered by the American Arbitration Association under its rules then in effect, and not in court before a judge or jury. The arbitrator's decision is final and may be entered as a judgment in any court of competent jurisdiction. Each party will bear its own attorney's fees and costs except as the arbitrator determines or applicable law requires.

3. No class actions. Claims may be brought only in my individual capacity and not as a plaintiff or class member in any class, collective or representative proceeding. **4. General.** This agreement is governed by Georgia law and the Federal Arbitration Act. If any part is found unenforceable, the remainder stays in effect. I may opt out of Section 2 (arbitration) only by written notice to Atlanta Body Retreat within 30 days of signing. **I have read this agreement, I understand that I am giving up my right to a court or jury trial and to bring or join a class action, and I agree to its terms.**

Client signature: _____ Date: _____

Printed name: _____ Parent/guardian (if under 18): _____

Therapist signature: _____ Date: _____