RENOVO
Integrative Massage & Renewal

Client History

Name (PLEASE PRINT): _____ Date: _____
Last Name First Name

Address: _____ Zip: _____
Street City State

Date of Birth: ____/____/____ Email Address: _____

Daytime Phone #: (____) _____ Evening Phone # (____) _____

Occupation / Work Environment / # of hours: _____

How did you hear about our healthcare provider services? _____

Have you ever received a professional massage or other bodywork? Yes No

If yes, what type(s)?

_____

Do you have a medical condition we should be aware of? *(This includes any major illness, past or present, injuries, tender spots and scars).* Yes No

If yes, please describe: _____

Be advised that prescription drugs alter the internal environment of the body. We suggest that you consult with your primary physician on the interaction of massage with any drugs you are currently taking.

Do you wear contact lenses? Yes No

Are you allergic to any skin oils or lotions? Yes No

If yes, what type(s)? _____

Are you involved in any regular exercise program? Yes No

What type? _____ How often? _____

PLEASE TURN OVER

Client Agreements

The Basics:

- No perfumes, scents, etc; good personal hygiene required.
- Not under the influence of drugs or alcohol.
- Cell phones off; if a call must be taken/made, let therapist know beforehand.
- The client is responsible for personal belongs.
- Control of pressure rests with the client; clients may ask for less pressure, may end massage session if uncomfortable.

Business Policies:

- **24-hour minimum notice of cancellation** or $10 fee is levied.
- A confirmation call from the therapist is solely a courtesy; the client is responsible for keeping his/her appointment with or without a confirmation call.
- The client will inform the massage therapist of all my known medical conditions.

Please initial EACH statement:

____The massage offered by the therapist is for therapeutic purposes only. Therefore, any sexually implicit behavior will result in the immediate termination of the session for which no refund will be given. Furthermore, I will relinquish my privilege of being a client of the therapist.

____The therapist does not diagnose illness, disease, or any physical or mental disorder; does not prescribe medical or pharmaceutical treatment; and does not do spinal manipulations. This massage is not a substitute for medical care by licensed health care providers.

____Any client under 18 is required to have a parent/guardian present during the massage.

I accept all the above policies: _____

Client's Full Signature

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CLIENT INTAKE FORM

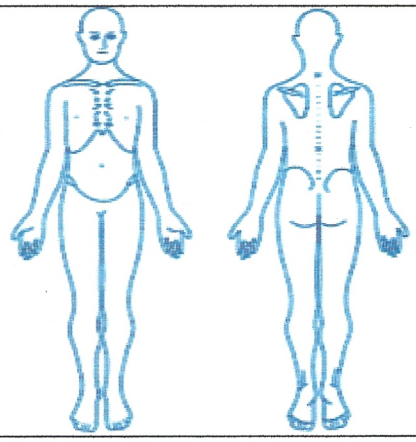
Name (please print) Last Name First Name

1. ARE YOU EXPERIENCING ANY OF THE FOLLOWING? Check all that apply. Date:

	Pregnancy		Bleeding		Skin Problems		Cancer
	Varicose Veins		Fever		Nausea/Vomiting		Arthritis
	Heart Problems		Gout		Bursitis		Diabetes
	Other:						

2. TENSION AND DISCOMFORT DIAGRAM:

On the diagram to the right ( ), shade in the area(s) where you are experiencing muscle tension or bodily discomfort



3. MEDICAL HISTORY UPDATE:

Since your last appointment, have there been any changes to your medical history?	NO	YES

If YES, please explain:

Additional information for your therapist:

Allergies to any lotions/oils? Y / N (If yes, please specify _____

Wear contact lenses? Y / N

Other information

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	Pregnancy		Bleeding		Skin Problems		Cancer
	Varicose Veins		Fever		Nausea/Vomiting		Arthritis
	Heart Problems		Gout		Bursitis		Diabetes
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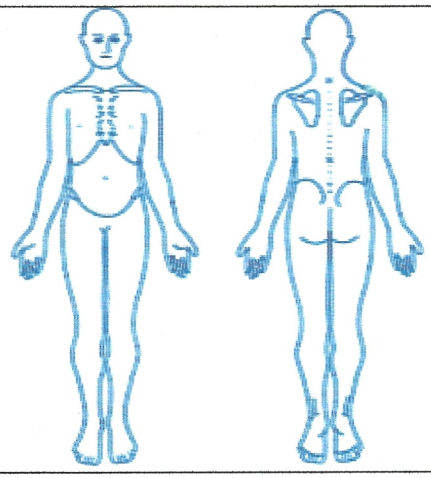

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BALANCE HARMONY SELF

To best protect your health and the health of others, please fill out this form before each massage and bodywork session. Thank you!

NAME: _____ DATE: _____

Have you been tested for COVID-19? If yes, what type of test did you have?

When was your test?

What were the results?

Have you been in places with a high infection rate within the last two weeks (e.g., state-designated "hotspots")? If yes, please explain.

Please check if you are experiencing any of the following as a NEW PATTERN since the beginning of the pandemic:

__ Fever __ Chills __ Cough __ Sore throat
__ Diarrhea, digestive upset __ Nasal, sinus congestion __ Loss of sense of taste or smell
__ Fatigue __ Shortness of breath
__ Sudden onset of muscle soreness (not related to a specific activity)
__ Rash or skin lesions (especially on the feet)

Do you have any new discomfort with exertion or exercise?

I declare that the information provided above is true and accurate to the best of my knowledge.

(print name) _____ (signature) _____(date) _____