

Body By Barb

CLIENT INTAKE & HEALTH HISTORY FORM

Name _____ Email _____
Phone (cell/day) _____ DOB _____ Age: _____
Address _____ City/State/Zip _____
Emergency Contact Name _____ Phone _____ Relationship _____
Occupation _____ Referred by: _____

Health Information

Are you taking any medications? yes no If yes, please list: _____

Any allergies? (oils, lotions, nuts, fruits, skin, etc.) yes no If yes, please list: _____

Are you pregnant? yes no If yes, how many months: _____ Due date: _____

Are you currently under medical supervision or receiving other medical interventions? yes no

If yes, please describe: _____

	No	Yes		No	Yes		No	Yes
Areas of swelling	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Back / neck problems	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	Heart condition	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Tendinitis	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	TMJ disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Neurological condition	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
Contagious condition	<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo / dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sensation	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>			

Areas of broken skin? (e.g. rash, wounds) yes no If yes, where? _____

History of joint replacement surgery? yes no Which joint(s) ? _____

Recent injuries or medical procedures in the past 2 years? yes no Please describe: _____

Please describe any other injuries or health conditions: _____

Massage Information

Have you had professional massage before? yes no How recently? _____

Reason for seeking massage: Relaxation Specific problem

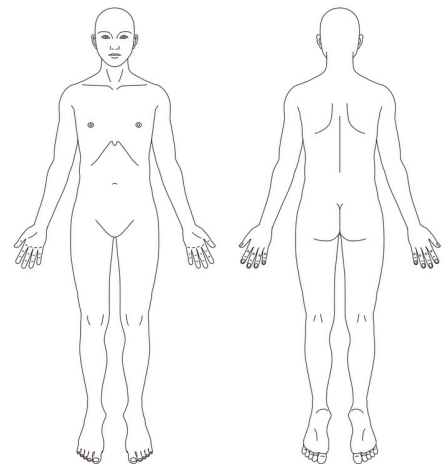
Please indicate any areas of discomfort

How much pressure do you prefer? Light Medium Firm

By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.

Client Signature _____ Date _____

Therapist Signature _____ Date _____



BODY BY BARB LLC

8 WINTER ST. TROY NY 12180 | BODYBYBARBLMT@GMAIL.COM | WWW.BODYBYBARBLMT.COM

Updated 3/1/2026

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Consent for Treatment & Liability Waiver

By signing below, you agree to the following:

- I voluntarily request and consent to receiving massage therapy.
- I understand that the massage services provided are intended for general wellness, stress reduction, and relief of muscular tension only.
- To the best of my knowledge, I do not have any injuries or conditions that would prevent me from safely receiving massage therapy. I understand the importance of informing my massage therapist of all known medical conditions and medications, and I acknowledge that additional risks may be associated with my physical condition.
- If I experience any pain or discomfort during the session, I will immediately inform my therapist so that the pressure or technique may be adjusted to my comfort level. I will not hold the massage therapist responsible for any discomfort I experience during or after the session.
- I understand that the potential risks associated with massage therapy include, but are not limited to:
 - Minor superficial bruising
 - Short-term muscle soreness
 - Aggravation of an unknown or pre-existing injury
- I affirm that I do not have any contagious conditions that could pose a risk to my massage therapist or other clients.
- I understand that either I or the massage therapist may end the session at any time for any reason.
- I have had the opportunity to ask questions regarding massage therapy, and all of my questions have been answered to my satisfaction.

I acknowledge that I have been informed of the policies and procedures related to massage therapy and that I understand them. I understand that massage therapy is not a substitute for medical care, and that I should consult a physician or qualified health provider for any medical concerns I may have. I further understand that massage therapists do not diagnose or treat illness, injury, or disease, and that nothing said during the session should be interpreted as medical advice or diagnosis. My consent is informed and voluntary, and I understand that I may withdraw it at any time, except for services already provided.

By signing below, I give my consent to receive massage therapy as described above.

Client Name (Please Print)

Client Signature

_____/_____/_____
Date

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POLICIES ACKNOWLEDGEMENT FORM

By signing below, you confirm that you have read, and understand the policies provided by this practice. These policies are intended to promote clear communication, mutual respect, and a safe, professional environment for both client and therapist.

The policies you are acknowledging include (but may not be limited to):

- Cancellation, Reschedule, & No- Show Policy
- Late Arrival Policy
- Draping Policy
- Massage Termination Policy
- Client Rights & Responsibilities
- Client Privacy & Confidentiality Policy

Your signature indicates that you:

- Have seen the location of these policies on the website bodybybarblmt.com
- Have read a physical copy of these policies while at Body By Barb LLC location.
- Understand and agree to abide by them
- Know how to contact the practice with questions or updates

Please review each policy carefully. If you have any questions or concerns, we encourage you to ask before signing this form.

Client Name (Please Print)

Client Signature

_____/_____/_____
Date

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