

Massage Therapy Client Intake Form

Name: _____ DOB: _____

Home Phone #: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Occupation: _____

Emergency Contact Name/Phone: _____

Are you currently under a physician's care? YES NO If yes, why? _____

Have you ever received massage therapy before? YES NO

Reason/goal for today's visit: _____

Please list all areas that you would like special attention today: _____

Are there any areas that you do not want massaged? _____

Medications, supplements, or vitamins? _____

Please check any conditions you have or have had:

- | | | |
|--|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Sprains or Strains |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Heart Attack | |

Joint Replacement(s): body parts and dates: _____

Allergies or Skin sensitivities: _____

Past Surgeries: _____

Do you have any other conditions that your massage therapist should be aware of prior to your massage? YES NO If yes, please list: _____

How do you typically prefer your massage pressure?

Deep _____ Moderate _____ Light _____ Not Sure _____

Client Status Report

_____ (initial) **Cancellation Policy: If you need to cancel your massage therapy appointment, please call at least 24 hours prior to your scheduled appointment time. Failure to do so could result in the full-service rate charged to your account.** And if you're running late, the courtesy of a phone call is always appreciated. We'll be happy to reschedule your appointment if possible. If we're not able to reschedule to another appointment time, your services will begin as previously scheduled, and your arrival time will determine the length of your treatment time, which will end as scheduled so the next guest may begin promptly.

Clients under the age of 18 must have a parent or legal guardian present to sign the paperwork. I understand that the purpose of massage is intended to enhance relaxation, promote stress reduction, reduce muscular tension, increase range of motion, and increase circulation. I am aware that the massage therapist does not diagnose illness or disease and does not prescribe medications. I understand that massage is not a substitute for medical treatment. It is recommended that I see a physician for any physical conditions; therefore, I have stated all my known medical conditions and will take it upon myself to keep the massage therapist updated on my physical health.

I am a guest of the Holy Family Memorial Wellness Center (HFMWC). As a guest, I have not provided any information about my health to HFMWC, participated in HFMWC Fitness Assessment or received any instruction from HFMWC. As consideration for permitting me to utilize the pool area of HFMWC, and other good and valuable consideration, the sufficiency of which is hereby acknowledged, I hereby agree as follows: I hereby assume full responsibility for and total risk of any injury, loss or damage (including injury to person or loss of property) sustained to me in, on, or about the premises of HFMWC); I hereby consent and agree that HFMWC and its affiliates, and their directors, officers, employees, agents, independent contractors and representatives shall not be liable for any such injury, loss or damage, for myself, and on behalf of my personal representatives, assigns, successors, executors, administrators, heirs, and next of kin; I hereby fully and forever, release and discharge HFMWC and its affiliates, and their representatives, from liabilities, claims, demands, rights of action or causes of action resulting from acts of omissions or active or passive negligence on the part of HFMWC and its affiliates, and the representatives, arising from injury, loss or damage sustained by me in, on, or about the premises of HFMWC, or resulting from my use or intended use of HFMWC facilities. I HEREBY AGREE THAT THIS ASSUMPTION OF RISK AND RELEASE OF LIABILITY AGREEMENT SHALL REMAIN IN FULL FORCE AND EFFECT UNTIL I REVOKE IT BY GIVING WRITTEN NOTICE TO HFMWC ON A FORM SUPPLIED BY HFMWC, AND THAT MY REVOCATION WILL ONLY APPLY TO EVENTS OR CIRCUMSTANCES OCCURRING AFTER THE DATE OF MY REVOCATION.

Signature: _____ Date: _____

A parent/legal guardian must sign for any client under 18 years of age:

Signature: _____ Date: _____