

## Massage Therapy Intake Form

Name \_\_\_\_\_ DOB \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ City, St, Zip \_\_\_\_\_

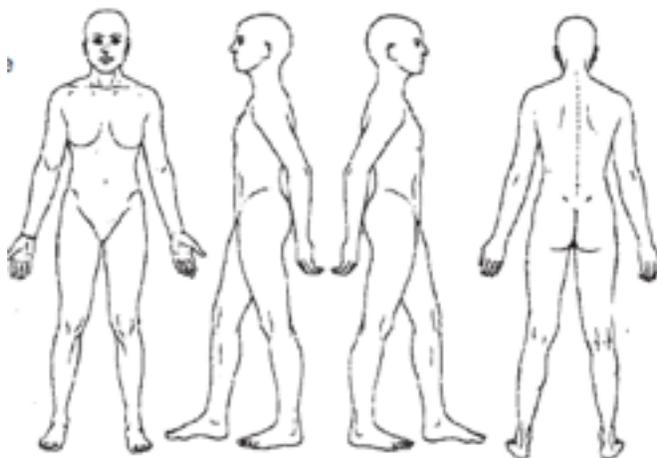
Email \_\_\_\_\_ Phone \_\_\_\_\_ Occupation \_\_\_\_\_

Occasionally we will need to contact you by email or text message about changes to your appointment or appointment reminders. Which method do you prefer?  Email  Text

1. Have you had a professional massage before?  Yes  No
2. Do you have any difficulty lying on your:  Back  Side  Stomach
3. Do you have any allergies to:  Nuts  Oils  Lotions
4. Do you have sensitive skin?  Yes  No
5. Are you wearing:  Contact lenses  Dentures  Hearing aid
6. Do you sit for long hours at a workstation, computer, or driving?  Yes  No
7. Do you experience stress in your work, family, or other aspect of your life?  Yes  No
8. Is there a particular area of the body where you are experiencing tension, stiffness, pain, or other discomfort?

Please explain:

Circle any areas in which you would like the Massage Therapist to focus on during your session.



9. Are you pregnant?  Yes  No **\*\*If yes, please see INFORMED CONSENT\*\***
10. Do you currently see a chiropractor?  Yes  No
11. Are you currently taking any medications?  Yes  No

Please check any condition listed that applies to you:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Contagious skin condition | <input type="checkbox"/> Phlebitis      | <input type="checkbox"/> Open sores or wounds     | <input type="checkbox"/> HBP/LBP         |
| <input type="checkbox"/> Deep vein thrombosis      | <input type="checkbox"/> Easy bruising  | <input type="checkbox"/> Joint disorders (RA, OA) | <input type="checkbox"/> Carpal tunnel   |
| <input type="checkbox"/> Recent accident or injury | <input type="checkbox"/> Osteoporosis   | <input type="checkbox"/> Recent fracture          | <input type="checkbox"/> Tennis elbow    |
| <input type="checkbox"/> Epilepsy                  | <input type="checkbox"/> Recent surgery | <input type="checkbox"/> Headaches/migraines      | <input type="checkbox"/> Varicose veins  |
| <input type="checkbox"/> Artificial joint          | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Sprains/strains          | <input type="checkbox"/> Atherosclerosis |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Current fever  | <input type="checkbox"/> Decreased sensation      | <input type="checkbox"/> TMJ issues      |
| <input type="checkbox"/> Swollen glands            | <input type="checkbox"/> Fibromyalgia   | <input type="checkbox"/> Allergies/sensitivity    | <input type="checkbox"/> Heart condition |

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◇ **Cancellation/Reschedule/No Show/Appointment Policy**

**Cancellation/Reschedule Policy:** Cancellations or rescheduled appointments must be done 24-hours prior to your appointment time. You will not be charged for your session if done 24-hours prior.

**No Show Policy:** No shows will be charged a 50% service fee from our full session price. (Example: a \$60 massage no show would be charged \$30.)

**Appointment Policy:** In order to be scheduled for your massage, you must place a valid credit card on file prior to your appointment. There are a limited number of appointment slots throughout the day, and no show appointments take up time that the Massage Therapist could be treating another client. For this reason, your credit card is put on file.

◇ **Informed Consent**

I hereby request and consent to the performance of massage therapy by the therapist/technician named below or other therapists/technicians at Spinalworks Medical Group. Massage in general provides benefits of stress reduction, relief from muscular tension, spasm, or pain, and it increases circulation and energy flow. I understand that massage therapists/technicians do not diagnose illness or disease, perform any spinal manipulations, nor do they prescribe any medical treatments. I am aware that therapeutic massage is not a substitute for medical examination, and I will seek health care for those services. I accept that massage promises no long-term results, nor will it cure my health problems. The therapist must be aware of all health conditions due to certain contraindications or cautions for massage. I have disclosed all such conditions. I will also update any changes to my health in future sessions.

If at any time during the massage the client or therapist/technician is uncomfortable for any reason, they shall immediately say so. **Sexual advances of any kind will not be tolerated.**

Children are not permitted in the massage room and must have childcare provided for them during the massage. Spinalworks Medical Group does not provide childcare services.

◇ **Pregnant Women Policy**

If you are in the first trimester of your pregnancy, please inform the staff or Massage Therapist before your massage. **We DO NOT offer massages for pregnant women in their first trimester.** Once you are out of your first trimester, you are able to receive a massage with a valid Doctor's note.

I have received and read written information concerning the possible benefits of massage therapy during pregnancy. I verify that I am experiencing a low risk pregnancy, and I have stated all my known medical conditions. I am aware that massage cannot be given during the first trimester of pregnancy.

◇ **Massage Package Refund Policy**

If you decide to purchase a package, whether after using a Groupon or one of our standard packages at discounted rates, please know that in order to receive the full discounted rate for each massage, you must use all the massages in the package you purchase. **WE DO NOT OFFER ANY CASH REFUNDS ON ANY OF OUR MASSAGE PACKAGES.** There are no exceptions. This includes packages after Groupon Purchases. Your remaining balance will be credited to be used on any other services in the office.

**By signing, I have read and understand all the policies on this page.**

Client Name (Printed) \_\_\_\_\_

Date \_\_\_\_\_

Client Signature \_\_\_\_\_