Bodies in Balance Massage Therapy

Client Intake Form

Personal Information

Name (last, first, MI) _____ Date of Birth _____

Address _____City _____State _____ZIP_____

Phone (Cell) _____ Phone (other) _____ Email _____

□ Opt out of coupons, newsletter, and other communication.

☐ Male ☐ Female Occupation _____ Emergency contact: _____

How did you find us?

☐ Referred by (please include full name so we can send them a thank you!): _____ ☐

Website (search engine: _____) □ Yelp □ Facebook □ Other _____

The following information will be used to help plan safe and effective massage sessions. Have you had a professional massage before? ☐ Yes ☐ No

Do you have any difficulty lying on your front, back, or side? ☐ Yes ☐ No If yes, explain _____

Do you have any allergies/sensitivities to scents, oils, lotions, or ointments? ☐ Yes ☐ No If yes, explain _____ Are you wearing ☐ contact lenses ☐ dentures ☐ a hearing aid?

Do you sit for long hours at a workstation, computer, or driving? ☐ Yes ☐ No If yes, explain _____

_____

Do you perform any repetitive movement in your work, sports, or hobby? ☐ Yes ☐ No If yes, explain _____

_____

Please describe types and frequency of physical activities and movement you engage in (sports, yoga, stretching, etc) _____

_____

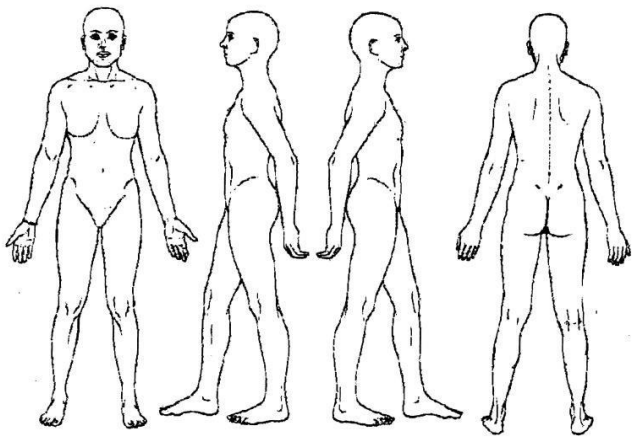
Are there any areas of the body where you are experiencing tension, stiffness, pain or other discomfort? ☐ Yes ☐ No

If yes, please explain _____

What are your goals for this massage session? _____

_____

Are you looking for ☐ A single session OR ☐ Long term relief



Indicate any specific areas you would like the massage therapist to concentrate on during the session:

P = areas with pain

X = areas with tightness

Continued on back ⟶

Medical History. **In order to plan a session that is safe and effective, we need some general information about your medical history.**

Are you currently under regular medical supervision? ☐ Yes ☐ No If yes, explain _____

Please list any medication (including herbs, supplements and over the counter medications) you are currently taking

_____

Please check any conditions that apply to you:

□ current cold, fever or illness
□ any skin disorder (psoriasis, athlete's foot, etc)
□ open sores or wounds
□ recent accident or injury
□ recent sprain/strain
□ recent fracture
□ recent surgery
□ phlebitis/varicose veins
□ thrombosis/blood clots
□ easy bruising □ joint disorder/ arthritis/tendonitis
□ back/neck problems or pain
□ osteoporosis
□ artificial joint
□ TMJ dysfunction/jaw pain
□ carpal tunnel syndrome
□ tennis elbow
□ plantar fasciatis
□ sciatica
□ bursitis
□ epilepsy
□ headaches/migraines
□ diabetes
□ decreased sensation
□ nervous system disorder
□ digestive system disorder
□ Fibromyalgia
□ swollen glands
□ allergies/sensitivity
□ heart condition
□ high or low blood pressure
□ circulatory disorder
□ varicose veins
□ cancer
□ pregnancy - if yes, how many months? ___
□ atherosclerosis
□ other

Please explain any condition that you marked above

_____

_____

_____

_____

Is there anything else that would be useful for your massage therapist to know to plan a safe and effective massage for you?

_____

Draping will be used during the session – only the area being worked on will be uncovered. Are there any parts of your body that you would not like to receive massage: □face/head □neck □pecs/chest □abdomen □back □gluteal/butt □arms □hands □legs □feet

Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 18.

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of Client _____ Date _____

Did you remember to turn off your cell phone?

Bodies in Balance Massage Therapy

Appointment Policies

Thank you for choosing our business! It is our intention to provide top notch care and service. Below are some guidelines to help us provide you with an optimum session.

Arrival at the Office

Please arrive at least 5-10 minutes ahead of your scheduled appointment (10-15 minutes for your first appointment). This little bit of extra time also allows your body and mind to start to transition from an active busy mode, into a more relaxed receiving mode, thereby enhancing your experience.

Our policy is that the length of your session is the amount of hands-on time you will receive. If you are seeing us for a specific pain complaint or sports performance issue, we will perform a thorough assessment to develop an effective treatment plan for you. Your hands-on massage time may be decreased slightly during your first appointment to allow for a detailed intake for a pain complaint or sports performance issue.

Late Policy

We understand that traffic, work, and other delays occur. **It helps a great deal if you call and let us know if you are running late.** We will do our best to accommodate you. If you are delayed more than a few minutes, your therapist will likely have to shorten your session. Full price will be charged.

Reschedule and Cancellation Policy

Recognizing that your therapist set aside the scheduled time just for you, and that we have other clients to consider we find it necessary to charge for last-minute cancellations and appointment changes.

Cancellation Fees

12-24 hr notice = $25 fee

12 hours or less = full price of session

Please initial to acknowledge policy _____

If a gift certificate was going to be used for an appointment, that certificate shall be forfeited.

We do understand emergencies, illnesses, and snowstorms do occur. **If you are sick, especially with a fever, vomiting, or diarrhea within 24 hours of your scheduled appointment, please cancel.** There will be no charge for these types of cancellations. There is no cancellation fee if you feel you cannot safely make it to our office due to winter weather and you provide us with 2 hours notice**.**

Professional Conduct

All services are professional and therapeutic. **There will be no sexual contact or conduct by client or therapist.** Should a client behave in a manner that violates this professional boundary, the session will be ended and the client will be required to pay for the session in full. Clients violating this policy will not be allowed to return to our business. Please initial to acknowledge policy: _____

We reserve the right to refuse service to any client.

Acknowledged by: _____ Date: _____