

Client Intake Form - B.Webb BodyWorks

Personal Information:

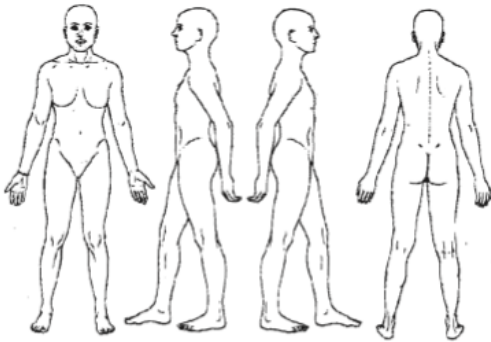
Name _____ Phone _____
Street _____ Date of Birth _____
City, State, Zip _____ Email _____
Emergency Contact _____ Phone _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Date of Initial Visit _____

1. Have you ever had a professional massage before? Yes No
2. Do you have any difficulty lying on your front, back, or side? Yes No
3. Do You have any allergies to lotions, oils, creams, or ointments? Yes No
If yes, please explain _____
4. Are you wearing contacts () dentures () or hearing aids ()
5. Do you sit for long hours at a workstation, computer, or driving? Yes No
6. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
7. Is there a particular area of the body where you are experiencing tension, stiffness, pain, sensitivity or other discomfort? Yes No
If yes, please identify _____
8. Do you have any particular goals in mind for this massage session? Yes No
If yes, please explain _____

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



Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

1. Are you currently under medical supervision? Yes No
If yes, please explain _____
2. Are you currently taking any medication? Yes No
If yes, please list _____

3. Please check any condition listed below that applies to you:

- | | |
|---|--|
| <input type="checkbox"/> contagious skin condition | <input type="checkbox"/> phlebitis |
| <input type="checkbox"/> open sores or wounds | <input type="checkbox"/> deep vein thrombosis/blood clots |
| <input type="checkbox"/> easy bruising | <input type="checkbox"/> joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis |
| <input type="checkbox"/> recent accident or injury | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> recent fracture | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> artificial joint | <input type="checkbox"/> headaches/migraines |
| <input type="checkbox"/> sprains/strains | <input type="checkbox"/> cancer |
| <input type="checkbox"/> current fever | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> swollen glands | <input type="checkbox"/> decreased sensation |
| <input type="checkbox"/> allergies/sensitivity | <input type="checkbox"/> back/neck problems |
| <input type="checkbox"/> heart condition | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> high or low blood pressure | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> circulatory disorder | <input type="checkbox"/> carpal tunnel syndrome |
| <input type="checkbox"/> varicose veins | <input type="checkbox"/> tennis elbow |
| <input type="checkbox"/> atherosclerosis | <input type="checkbox"/> pregnancy If yes, how many months? _____ |

4. Have you ever experienced trauma that may impact your treatment? Yes No

5. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

Draping will be used during the session – only the area being worked on will be uncovered.

Clients under the age of 17 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 17.

I, _____ (print name) 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 _____

Signature of Massage Therapist _____ Date _____

Please take a moment to review and sign the below policies and procedure.

- Please arrive 15 mins prior to your appt. This will allow you time to fill out appropriate paperwork & get yourself settled. Unfortunately running late may prevent you from enjoying a full session
- Tardiness of more than 15 minutes (without notification) may forfeit your session and require your appointment to be rescheduled.
- Please provide 24 hours notice if you need to cancel an appt. While I completely understand that life happens, 3 cancellations without sufficient notice will require prepayment of future sessions.
- Payment in full is due at the time of service.
- A \$25.00 fee will be assessed on all returned checks. Two or more instances of insufficient funds will require prepayment of future sessions.
- Please use Gift Certificates within one year of issue. Gift Certificates are non transferable and not redeemable for cash.
- Sexual Harassment will not be tolerated. If sexually explicit remarks are made or sexual favors are requested or implied, your session will be terminated immediately. In this instance, you will be responsible for the full cost of the original session scheduled and will be asked not to return for further treatments. Requests for illegal/ illicit activities will be reported to the proper local authorities.
- Sessions can not be performed if the client is under the influence of drugs or alcohol.

I reserve the right to refuse service or terminate treatment at any time, at my discretion.

I have read the above office policies and procedures and give consent to treatment.

(Print Name and date) _____

(Sign Name and date) _____