Massage & Reflexology Intake

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| Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | |
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| Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Preferred name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you receive text/sms  Yes  No | |
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| Home telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
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| Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Whom may we thank for referring you? | |
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| Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Name and Phone #) | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
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| What major concerns brought you here today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
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| Do you have any other issues that bother you on a regular basis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
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| Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | | --- | | **Health History**  Please check the following conditions that apply to you, whether past or present |  |  |  |  | | --- | --- | --- | | **Musculoskeletal** | | | | o Headaches  o Joint stiffness  o Spasms/cramps  o Broken bones  o Sprains  o Back/hip pain | o Shoulder/neck pain  o Arm/hand pain  o Leg/foot pain  o Chest/abdominal pain  o Jaw pain/TMJD  o Tendinitis | o Bursitis  o Osteoarthritis  o Rheumatoid arthritis  o Scoliosis  o Bone or joint disease  o Trouble walking | | **Circulatory and Respiratory** | | | | o Dizziness  o Shortness of breath  o Fainting  o Swollen ankles  o Blood clots | o Heart failure  o Heart attack  o Sinus issues  o Asthma  o Seasonal allergies | o High blood pressure  o Low blood pressure  o Varicose veins  o Lymphedema | | **Skin** | | | | o Rashes  o Allergies  o Fungal infection | o Ulcers  o Warts  o Moles | o Acne  o Cosmetic surgery  o Chemical sensitivity | | **Nervous system** | | | | o Numbness/tingling  o Migraines  o Chronic pain  o Stroke | o Fibromyalgia  o Paralysis  o Epilepsy  o MS/MD /Parkinson’s | o Herpes/shingles  o Benign tremor  o Cerebral palsy  o Brain/spine injury | | **Other** | | | | | | | |
| Please READ and check All boxes. Signing this document affirms you have read and agree to all items.   * I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (client) understand that massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, and offer a positive experience of touch. * I understand the general benefits of massage, contraindications, and treatment procedures. * I understand that bodywork is not a substitute for medical treatment or medications. * I understand that the therapist does not diagnose illness, does not prescribe medication, and that spinal manipulation is not part of the therapy. * I also understand that certain contraindications exist for massage therapy and I will inform my massage therapist immediately if any changes to my health profile occur. * Arrival Time: We ask that you please arrive on time; any tardiness will result in time deducted from your session. If you are a new client, we ask you to arrive a few minutes early to take time and fill out any forms necessary or you may print the forms from our website and bring them filled out. * Scheduling: In order to better fit your needs, 4EB asks for you to schedule your appointment in advance. Although, same day appointments are sometimes available, they are not guaranteed. We ask to schedule about one week in advance. We have convenient online scheduling. * **In case of illness:** We are unable to work on you if you become ill. Fever the afternoon /evening before an appointment means you are contagious. Although you may think massage will help you, your illness could infect the therapist, their family, and other clients. If you become ill please call as soon as possible to reschedule, so we will have the opportunity to fill your spot. We understand occasionally illness is unforeseen, please understand if this happens *often* then the Cancellation Policy will be in effect. * Minors under 18 years may not receive services unless a guardian has given written permission and (if possible) stays present. * Clothing: The client may choose to leave on as much clothing as needed for comfort, refuse any massage methods, stop massage at any time and is free to leave. If the session goes past 15 minutes, full payment will still be required. * Draping: The client will always be modestly draped. Only the area being massaged will be undraped. The clients will be kept informed of the area to be massaged. * I agree that my massage therapist will not be held liable for any negative effects if I fail to update my profile or provide complete information. * I affirm that I have answered all questions pertaining to medical conditions I understand that if I experience any pain or discomfort during my session, I will immediately inform the therapist. * I also understand that massage should not be considered a substitute for medical examination, diagnosis or treatment and I agree to seek qualified medical care for any mental or physical illness that I am experiencing. I recognize that massage therapists are not qualified to diagnose, treat or prescribe for illness or injury and I will request a referral if such is required. * I understand a agree to the Cancellation Policy: If you are unable to make your appointment for any reason, we ask you give at least 24 hours’ notice to cancel or reschedule. Failure to do so will result with mandatory billing of $75 for missed/reschedules appointment. If a gift certificate was to be used, $75 will be deducted from the certificate. If you do not have a credit card on file, this will be due before scheduling your next appointment. * Gift Certificates: Gift Certificates & Vouchers are non-refundable and must be presented at time of service. Lost or stolen certificate/vouchers are also non-refundable and are invalid, for online certificates/vouchers we will check our records, as a courtesy, and if it is unused we will honor it. * I understand that there shall be no liability on the part of the therapist due to my forgetting to relay any pertinent information. * I understand that it is my own responsibility to communicate with the therapist if I feel any pain or discomfort during the session so that the treatment can be adjusted. * I understand that therapeutic bodywork is NONSEXUAL in nature. Any sexual overtures by the client will result in the *immediate termination* of the session and the therapeutic relationship and *full payment will still be due*. * I give permission to be contacted by email , phone, and sms/text for appointment confirmation and reminders, as well as newsletters, announcements and events. | | | | |
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| Please list all prescription and  Nonprescription drugs/supplements, including alcohol/nicotine use:  (if you are unsure of drug names, list reason you are taking them) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| History of car accidents, falls, concussions, whiplash injuries, serious illnesses: Date(s) Incident  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| In general, how is your health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What are your major stressors? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Any history of cancer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| Have you had any surgeries? Date(s) Surgery |
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| Anything else I need to know? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| By signing below, I am have read and am in full agreement and will abide by the above policies. |
| Signing this document affirms you have read, understand and agree to all items.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature Date |