Massage and Bodywork Intake Form

Client Information

Date _____

Name _____ Date of Birth _____

Street _____ Phone _____

City _____ State _____ Zip _____ Okay to Text? Yes | No

Occupation _____

Email _____ Referred By _____

Emergency Contact Name _____ Phone _____

Massage History / Session Information

Have you ever received a professional massage? ☐ Yes ☐ No Date of last massage _____

What result do you want from your bodywork sessions? _____

List any exercise activities. Include frequency: _____

_____

Are you currently under the care of a health care practitioner? ☐ Yes ☐ No

If yes, specify purpose: _____

List current medications and purpose: _____

_____

Previous History (Include year and treatment received)

Injuries/accidents/illnesses still affecting you: _____

_____

Surgeries (include year) _____

_____

_____

Please mark any of the following that you now have or have had.

Musculoskeletal

- ☐ Bone or joint disease
- ☐ Tendonitis / Bursitis
- ☐ Arthritis / Gout
- ☐ Jaw pain (TMJ)
- ☐ Lupus
- ☐ Spinal Problems
- ☐ Other : _____

Circulatory

- ☐ Heart Condition
- ☐ Phlebitis / Varicose Veins (circle one)
- ☐ Blood Clots
- ☐ High / Low Blood Pressure (circle one)
- ☐ Lymphedema
- ☐ Thrombosis / Embolism
- ☐ Other : _____

Please mark any of the following that you now have or have had. (Continued)

Respiratory

- ☐ Breathing difficulty / Asthma
- ☐ Emphysema
- ☐ Allergies specify: _____
- ☐ Sinus Problems
- ☐ Other : _____

Nervous System

- ☐ Shingles
- ☐ Numbness / tingling
- ☐ Pinched Nerve
- ☐ Other : _____

Reproductive

- ☐ Pregnant: Stage
- ☐ Ovarian / menstrual problems
- ☐ Prostate
- ☐ Other : _____

Additional Client Remarks / Comments:

_____

_____

_____

_____

Skin

- ☐ Allergies specify: _____
- ☐ Rashes
- ☐ Athletes foot
- ☐ Herpes / cold sores
- ☐ Other : _____

Digestive

- ☐ Irritable bowel syndrome
- ☐ Constipation
- ☐ Ulcers
- ☐ Other : _____

Other

- ☐ Cancer / tumors
- ☐ Bladder / kidney ailment
- ☐ Pacemaker
- ☐ Port
- ☐ Diabetes
- ☐ Drug / alcohol / caffeine / tobacco use
- ☐ Chronic fatigue
- ☐ Chronic pain
- ☐ Sleep disorders
- ☐ Migraines
- ☐ Headaches
- ☐ Anxiety / stress syndrome
- ☐ Depression
- ☐ Breast augmentation
- ☐ Botox injections, fillers, etc.

• I have completed this form to the best of my knowledge and will inform the massage therapist of any change in my physical health.

• I understand that a massage therapist can not diagnose illness, disease, or any other medical, physical, or emotional disorder, nor perform any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailments that I have

• I understand that massage therapy is a therapeutic health aide and is non-sexual.

• I understand that if the massage therapist starts a session late, she will make it up to me at the end of my session if possible, or will reduce my fee accordingly. I understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized.

• I agree to give 24-hour notice for a scheduled session that I can not keep. I am aware that I may be charged the full fee for any missed sessions or for sessions that I do not give 24-hour notice to cancel or reschedule.

Signed _____ Date _____

Cancellation Policy Agreement

You will receive an email reminder 48 hours prior to your appointment, as well as a text reminder 24 hours prior to your appointment. **I respectfully ask that you provide me with 24 hours notice of any schedule change or cancellation requests.**

When you cancel or miss your appointment, I am often unable to fill that appointment time due to many of my clients receiving therapy on a pre-determined schedule. This has a financial impact on my practice and also means my other clients miss the chance to receive services they need.

For this reason, you will be charged:
- 50% of the service fee for the first late cancellation (within 24 hours), and
- 100% of the service fee for each late cancellation after that
- 100% of the service fee for any "no call no show" missed appointment

Repeated rescheduling of appointments may require prepayment in order to secure future appointments. This payment is non-refundable and non-transferrable.

I understand that illnesses do occur at inconvenient times. I request that you cancel your session if you are experiencing the following:
- fever
- known infection or acute cold and/or flu symptoms
- vomiting or diarrhea within 24 hours prior to your appointment time

Inclement weather may also result in the need for late cancellations. I will do my best to give advance notice if I am closing or need to cancel due to bad weather and I ask you to do the same. Please do not risk your own safety trying to make your appointment.

Late cancellation due to illness or inclement weather will generally not result in any missed session charges and will be determined on a case-by-case basis. Any cancellation not due to inclement weather or illness is subject to a cancellation fee.

A valid credit card will be kept on your profile in my secure client management software for billing of any cancellation fees.

I authorize Brooke Dominey, LMT, CDT to charge my credit card the appropriate above fees for no-show and late-canceled/rescheduled (less than 24 hours) appointments. I understand that my personal billing information will not be shared with other parties and will remain in my secure file.

By signing below, I agree to abide by these policies.

_____ _____

Signature Date

_____

Printed Name