

MEDICAL HISTORY INTAKE

Name: _____

Date of birth: _____

Address: _____

Phone number: _____

City/State/Zip: _____

Email: _____

List any injuries/surgeries you've had (recent or past): _____

List any skin allergies and conditions: _____

What would you like to achieve from this session? (Circle) Relaxation Relieve pain Other: _____

Have you had any massages before? Y or N

If no, do you have any questions/concerns? _____

I have completed this information form to the best of my knowledge. I understand the massage services are designed to be a health aid and are not a replacement for medical attention from a doctor. Information exchanged during any massage session is educational and is intended to help me become more familiar and conscious of my own health status and is to be used at my own discretion.

Our time together is important, and I agree to cancel 24 hours in advance. Unless there is an emergency, if I miss an appointment, I agree to pay the full appointment fee.

Client Signature:

Date:

Therapist Signature:

Date:

INFORMED CONSENT

I have received, read, and understand the policies and procedures (page 3). The therapist has informed me of his/her qualifications, the kind of massage service to be provided, the benefits, risks, and the goals of the session that we have agreed upon. I understand that I retain the right to withdraw my consent at any time during any session.

I understand that the massage services provided by the therapist are intended to promote relaxation and circulation, relieve stress, muscle tension, spasms, and related pain. I understand that the massage therapy is not a substitution for medical treatment or medication.

I have informed the therapist of my medical and physical conditions and of medication I use, and I agree to update the therapist of any changes in my health profile. I release the therapist of any liability if I fail to do so.

If I experience any discomfort or pain during any session, I will immediately inform the therapist so adjustments can be made to the treatment.

Client Signature:

Date:

CONSENT TO TREAT A MINOR

I, the parent/legal guardian of (dependent's name) _____ authorize (therapist name) _____ to provide massage treatments to my dependent/child.

Guardian Signature:

Date:

POLICIES AND PROCEDURES

Services:

- Therapeutic massage- 60 minute
- Oncology massage- 60 minute

Tips are greatly appreciated, but not necessary.

Cancellation/Late Arrival/No Show Policy:

Please provide at least 24 hours notice if you need to reschedule or cancel a treatment. This gives the therapist enough time to fill the slot. If a client fails to cancel within 24 hours they will be charged the full amount.

We regret that late arrivals will not receive extension of scheduled appointments. In special cases, and when our schedule will allow, we may be able to accommodate a partial or full appointment. This will be at our discretion. The original reservation fee will be charged.

If a client no shows, our therapists don't get paid, so it is important that our massage therapists are compensated for the reserved time slots.

Draping Policy:

The client will always be modestly draped, only the area being massaged will be undraped. The therapist will maintain personal privacy and ensure safety/comfort for both the client and therapist. Talk to the therapist if you have ANY concerns.

Minors:

Clients under the age of 18 must have a parent/guardian present to fill out the consent form. Minors will be denied service if parent or guardian is not present. The parent or guardian is allowed to stay in the room during treatment if minor requests.

Conduct of Behavior:

Massage is for relaxation and therapeutic purposes only. There is no sexual component to massage at all. Any insinuation, gesture, or conversation will result in immediate termination of session and refusal of future services. Client will be charged full session fee. If necessary, a report will be filed with local authorities.

Client Signature:

Date: