BEAUTY BAR SALON & MED SPA

MASSAGE THERAPY INTAKE FORM

-----CONFIDENTIAL-----

So that we may provide you with the best care, please complete these forms.

CLIENT INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Occupation: _____ Areas of Concern: _____

Emergency Contact: _____Phone Number: _____

How did you hear about The Beauty Bar? _____

HEALTH HISTORY

Please answer the following questions with YES or NO. If YES, please explain.

- Are you taking any medications and/or OTC drugs? _____ Yes _____ No

If yes, please explain: _____

_____

- Have you had a recent major surgical procedure or injury? _____ Yes _____ No

If yes, please explain: _____

_____

- Are you currently seeing a Chiropractor, Physical Therapist, or Physician for an ongoing issue?

_____ Yes _____ No

If yes, please explain: _____

_____

Please indicate your stress level on the following scale:

LOW 1 2 3 4 5 HIGH

Do you have ANY lotion or oil allergies? _____ Yes _____ No

If yes, please explain: _____

_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?

PLEASE CHECK ALL THAT APPLY.

- ☐ Headaches
- ☐ Joint Stiffness/Swelling
- ☐ Spasms/Cramps
- ☐ Broken/Fractured Bones
- ☐ Strain/Sprains
- ☐ Back/Hip Pain
- ☐ Shoulder/Neck/Arm/Hand Pain
- ☐ Leg/Foot Pain
- ☐ Chest/Ribs/Abdominal Pain
- ☐ Problems Walking
- ☐ Jaw Pain/TMJ
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Dizziness
- ☐ Shortness of Breath
- ☐ Fainting
- ☐ Cold Hands or Feet
- ☐ Cold Sweats
- ☐ Stroke
- ☐ Heart Condition
- ☐ Allergies
- ☐ Asthma
- ☐ High OR Low Blood Pressure
- ☐ Indigestion
- ☐ Constipation
- ☐ Intestinal Gas/Bloating
- ☐ Diarrhea
- ☐ Irritable Bowel Syndrome
- ☐ Chron's Disease
- ☐ Colitis
- ☐ Numbness/Tingling
- ☐ Fatigue
- ☐ Sleep Disorder
- ☐ Ulcers
- ☐ Paralysis
- ☐ Herpes/Shingles
- ☐ Cerebral Palsy
- ☐ Epilepsy
- ☐ Chronic Fatigue Syndrome
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's Disease
- ☐ Rashes
- ☐ Athlete's Foot
- ☐ Acne
- ☐ Impetigo
- ☐ Hemophilia
- ☐ Loss of Appetite
- ☐ Depression
- ☐ Difficulty Concentrating
- ☐ Hearing Impaired
- ☐ Visually Impaired
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Post/Polio Syndrome
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Thyroid Condition
- ☐ Autoimmune Disorder

CONSENT FOR THERAPY AND WAIVER OF LIABILITY

I understand ("Client") herby freely consents to receipt of massage from _____ (MT Name)

Client agrees as follow:

Client understands and agrees that they will provide the Therapist with a complete and accurate health information, and a written referral from Client's primary healthcare provider if Client is currently receiving care or has a specific medical condition or symptoms for which the Client takes medication and receives periodic evaluations or treatment. Client understands that massage therapy is designed to be an ancillary health aid and is not suitable for primary medical treatment for any condition.

1. Client and Therapist have discussed the potential benefits and possible side effects of massage therapy and have agreed upon a course of focused attention and manually therapy for the predetermined goals of stress reduction, relief of muscular discomfort, and/or promotion of general health. Client has been given an opportunity to ask questions of the Therapist and has received all requested information.
2. Client understands that the unclothed body will be draped at all times for warmth, sense of security, and as a mark of massage therapy professionalism. Client agrees to immediately inform the Massage Therapist of any unusual sensation or discomfort so that the application of pressure may be adjusted to the Client's level of comfort. Client understands that massage therapy is not sexual in any manner and that any illicit or suggestive remarks or behavior on the client's part, will result in an immediate termination of the therapy session. Client understands that payment will be expected in full; regardless if the massage is completed or not.
3. Client hereby assumes full responsibility for receipt of the massage therapy, and releases and discharges Therapist from any and all claims, liabilities, damages, actions, or causes of action arising from the therapy received hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the therapist to the fullest extent of the law.
4. Client, in signing this consent for Therapy and Waiver of Liability ("Consent"), understands and agrees that this Consent will apply to and govern the current and all future therapy sessions performed by the therapist.

I understand that a Massage Therapist does not diagnose disease, illness, or prescribe any treatment or drugs, nor do they provide any spinal manipulation. I understand that draping will be used at all times and that breast massage will not be administered on female clients. I understand that if I become uncomfortable for any reason that I may ask the Therapist to end the massage session, and they will end the session. I understand that the Massage Therapist may end the session for any inappropriate behavior. I have stated all of the conditions that I am aware of, and this information is true and accurate. I will inform the health care provider of any changes.

Client Signature _____ Date _____