



Client Intake Form

Name: _____ Phone: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

Email address: _____

DOB: _____ Occupation: _____ Male Female

Emergency Contact: _____ Phone: (_____) _____

Please help our marketing dollars be effective. How did you hear about us? _____

Have you ever experienced a professional massage or bodywork session? Yes No

If yes, how recently? _____

What are your massage or bodywork goals? _____

Mark on the scale what kind of pressure you prefer. Remember pressure does not equal depth.

Feathers only

Crush my bones

If you answer "yes" to ANY of the following questions, please explain as clearly as possible.

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience frequent headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high blood pressure? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have tension or soreness? | <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you on medication for it? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from back pain? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from epilepsy or seizures? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have numbness or stabbing pains? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have cardiac or circulatory problems? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had any injuries in the past two years? | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had any lymph nodes removed? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you sensitive to pressure in any areas? | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you gone through chemo or radiation? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking any blood thinners? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a history of aneurysms or embolisms? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a birth control patch or implant? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any contagious diseases? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from arthritis? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any allergies? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from joint swelling? | Comments: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have varicose veins? | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you bruise easily? | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had broken bones in the past two years? | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have osteoporosis? | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have diabetes? | |

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

Appointment Policies

Please read and initial each line.

1. _____ I understand that ALL appointments are prepaid. Appointments canceled on the same day will forfeit the entire session amount. Exceptions for emergencies will be granted on a case-by-case basis. More grace is given the sooner the office is aware of the emergency. If an exception is made, the amount paid (minus transaction fees) will be refunded or credited to your HGBT account to be used at a later date.

2. _____ I am aware that all appointment reminders are sent by email and text message through our automated system. I can use either one of these methods to communicate with the office staff or I can call the office.

I prefer my text message reminder to be sent within the following timeframe: (Please check one)

- 2 hours 3 hours 6 hours 12 hours 24 hours 48 hours
- 72 hours No text (this means you will not receive reminders via text)

You are responsible for your appointments; however, we want to do everything we can do help you remember.

Yes No **May we communicate/dialogue with you via text regarding your appointment?**

3. _____ I understand that my appointment time is reserved for me only. I understand that in order to start my session on time, I should arrive 5-10 minutes early.

4. _____ I acknowledge that I am responsible to be on time for my appointments and that the therapist is not under any obligation to extend my therapy session if I am late.

5. _____ I understand that I will be charged an additional \$30.00 fee for any returned checks.

(Client Signature)

(Client Printed Name)

(Date)

Massage Patient Information & Informed Consent Form

Please read and initial each line.

1. _____ I understand that massage bodyworkers and holistic practitioners are not medical doctors and do not diagnose illness, disease, or any physical or mental disorder. I acknowledge that massage and alternative holistic therapies are not substitutes for medical treatment, and that Healing Hands Body Therapy, Inc., recommends I see a primary healthcare provider for that service.
2. _____ I understand that it is my responsibility to communicate with my therapist if I have concerns or questions about my session. I do not have any injuries or conditions that would prevent me from receiving a massage, nor have I been told by a health care provider that I should not receive massages or alternative therapies.
3. _____ I understand that massage therapy and bodywork services are a therapeutic health aid and are non-sexual. I understand that my massage therapist reserves the right to end a therapy session in the case of sexual innuendo or advances from the client. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the massage, and I will be liable for full payment of the scheduled session.
4. _____ Any information exchanged during a massage or bodywork session is confidential and is only used to provide me with the best health care service available. I understand that a massage therapist will ask me questions about my health and physical condition and that I am obligated to answer truthfully and honestly about my health history in full detail.
5. _____ I understand that my feedback is essential in my treatment, and that if I experience any unusual discomfort and/or pain during my massage session, it is my responsibility to inform the therapist in order to enable the therapist to adjust the pressure or technique being used.
6. _____ The therapist reserves the right to decline, discontinue, or restrict services based on any provided information that may indicate that massage therapy session would put my health or the therapist's health at risk.
7. _____ I understand that massage therapy and bodywork is for the purposes of stress reduction, relief from muscular tension, muscle spasms, general relaxation, and improvement of circulation.
8. _____ I understand that the therapist has the right to refuse service to me if I come in for an appointment with the appearance of being under the influence in any way shape or form.
9. _____ I understand that for my own personal safety and comfort it is necessary for me to disclose any medications taken for pain within 24 hours of my appointment.
10. _____ I have stated all of my known medical conditions on the Client Intake Form. I have consulted a medical doctor or licensed medical health care practitioner regarding any checked or described conditions.
11. _____ I am, to the best of my knowledge, not ill. (No fever or any issue that may be contagious)
12. _____ I understand that it is solely my responsibility to keep the therapist updated on any changes in my physical health, and I further understand that the company and the therapist shall not be liable for any purpose and for any reason whatsoever, should I fail to update the therapist with any change in my health.
13. _____ I have not reviewed this in its entirety and promise to give up my first-born child.