NEW CLIENT CONSULTATION FORM

PERSONAL INFORMATION

Name: _____ Date: _____

Date of birth: _____ Age: _____ ☐ Female ☐ Male ☐ NB

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency contact: _____ Phone #: _____

How did you hear about us? _____

Would you like to be added to our email list for news and exclusive offers? **Yes** ☐ **No** ☐

MEDICAL HISTORY

Please check any conditions below that applies to you:

- ☐ Arthritis / joint disorder
- ☐ Artificial joint
- ☐ Atherosclerosis
- ☐ Blood disorder
- ☐ Back/neck problems
- ☐ Cancer
- ☐ Carpal tunnel syndrome
- ☐ Circulatory disorder
- ☐ Contagious skin condition
- ☐ Decreased sensation
- ☐ Deep vein thrombosis/blood clots
- ☐ Diabetes
- ☐ Easy bruising
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Fibromyalgia
- ☐ Headaches/migraines
- ☐ Heart condition
- ☐ High/low blood pressure
- ☐ Immune disorders
- ☐ Keloid scarring
- ☐ Open sores or wounds
- ☐ Osteoporosis
- ☐ Phlebitis, blood clots
- ☐ Pregnant
- ☐ Recent accident or injury
- ☐ Recent fracture
- ☐ Seborrhea
- ☐ Seizure disorder
- ☐ Skin disease/lesions
- ☐ Sprains/strains
- ☐ Swollen glands
- ☐ Tennis elbow
- ☐ TMJ
- ☐ Varicose veins

Please explain any condition that you have marked above: _____

_____

Any other condition? ☐ No ☐ Yes: _____

Any recent surgery, including plastic surgery? ☐ No ☐ Yes, explain: _____

MASSAGE THERAPY CONSULTATION FORM

MASSAGE INFORMATION

Have you had a professional massage before? ☐ No ☐ Yes

Do you have sensitive skin? ☐ No ☐ Yes

Do you have any difficulty lying on your front, back, or side ? ☐ No ☐ Yes: _____

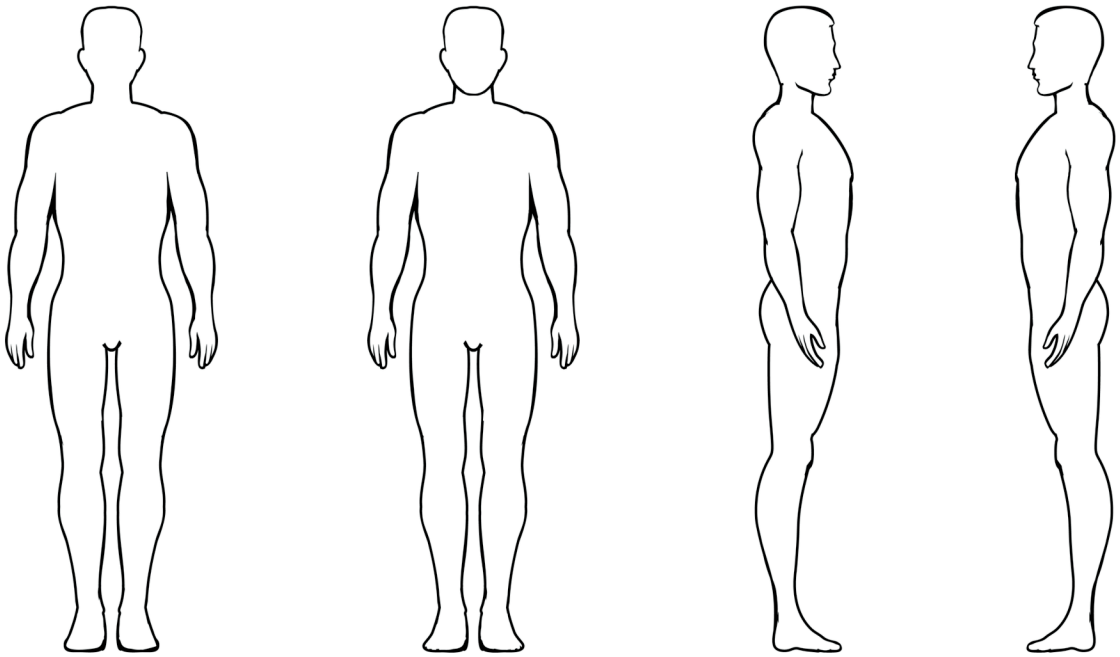
Do you have any allergies to oils, lotions, or ointments? ☐ No ☐ Yes: _____

What type of massage are you seeking? ☐ Relaxation ☐ Therapeutic/deep tissue

What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep

Are there any areas (feet, face, abdomen) you do not want massaged? _____

Mark any specific areas you would like your therapist to concentrate on:



Front Back Right Left

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Client Name (printed) :

Client Name (signature) : Date:

CLIENT CONSENT FORM

SCOPE OF PRACTICE

Massage Therapy is a profession in which the practitioner applies manual techniques, and may apply adjunctive therapies, with the intention of positively affecting the health and well-being of the client. Massage Therapists do not diagnose or prescribe for medical conditions nor are they allowed to provide treatment for a specific condition without a doctor's supervision. The massage therapist is required to refer you for diagnosis and to follow recommendations of your physician. The massage therapists are happy to adjust pressure, temperature, music volume, work longer on an area or move on if you request it.

MEDICAL CONDITIONS

It is the responsibility of the client to keep the massage therapist informed of any medical treatment currently being taken, and to provide written permission from the physician, chiropractor, physical therapist, etc., that the massage may be continued. The client must also keep the massage therapist informed of any changes in health conditions.

CONSENT

I _____ understand that if I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that Massage Therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. Massage should not be performed under certain medical conditions and I affirm that I have stated all my known medical conditions, and answered all questions honestly. I will keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist should I fail to do so. _____(Initials)

This is a Therapeutic Massage session and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment. _____(Initials)

I understand the Massage Therapist practitioner reserves the right to refuse services to me for any reason that she deems necessary. _____(Initials)

Client Name (printed) :

Client Name (signature) : Date:

Therapist: Date:

APPOINTMENT CANCELLATION POLICY

Our goal is to provide quality care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy.

Appointments are in high demand, and your early cancellation will give another person the opportunity to have access to timely care. This policy enables us to better utilize available appointments for our clients.

At the time of booking your appointment, either online or over the phone, you will be required to pay the full price, in advance, for the services you wish to schedule. This is mandatory.

Time has been specifically reserved for your appointment, procedure, or treatment.
If you need to cancel or reschedule your appointment, you must do so at least 24 hours prior to your appointment and your payment will either be refunded or pushed to a future appointment.

However, if you do not cancel within 24 hours or are more than 15 minutes late for your appointment, you will be considered a 'no show' and you will be charged ONE HALF of the price of the original appointment fee.

If you are less than 15 minutes late, we will not extend your treatment time. Your session will end as scheduled and you will be charged your original fee. There are also no roll-over minutes.

We are happy to answer any questions regarding this cancellation policy.

I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by it's terms. I agree to pay the cancellation fee in the event of a missed appointment.

Client Name (printed) :

Client Name (signature) : Date:

COVID-19 LIABILITY WAIVER AND RELEASE FORM

I am aware that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. And I understand that COVID-19 is extremely contagious and believed to spread through person-to-person contact.

Please respond to the following questions truthfully and to the best of your ability.

Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms? Yes ☐ No ☐

- Fever
- Cough
- Fatigue
- Shortness of breath
- Difficulty breathing
- Sore throat
- New loss of taste or smell
- Chills
- Head or muscle aches
- Nausea, diarrhea, vomit
- Congestion or runny nose
- Body or muscle aches

In the past 14 days, have you or anyone in your household traveled outside of _____? Yes ☐ No ☐

In the past 14 days, have you been in close proximity to anyone who has tested positive for COVID-19? Yes ☐ No ☐

Have you been tested for COVID-19 and are waiting to receive test results? Yes ☐ No ☐

RELEASE AND WAIVER

By signing this agreement, I voluntarily assume the risk that I may be exposed to or infected by COVID-19.
I hereby release and hold harmless _____ , from any and all liabilities related to COVID-19 exposure. EVEN IF ARISING FROM THE NEGLIGENCE, ACTS OR OMISSIONS OF THE RELEASED PARTIES.

Print name: _____

Signature: _____ Date: _____