MASSAGE INTAKE FORM

PATIENT DATA			
TITLE: ❑ MR. ❑ MRS. ❑ MS. ❑ MISS (CHECK ONE)			DATE:
FIRST NAME:	MI:	LAST NAME:	
ADDRESS LINE 1:			
ADDRESS LINE 2:			
CITY:	STATE:	ZIP CODE:	
HOME PHONE:		WORK PHONE:	
CELL PHONE:	DOB:	AGE:	SEX: ❑MALE ❑FEMALE
WHAT IS YOUR OCCUPATION:		EMPLOYER NAME:	
IS IT OKAY TO CALL YOU AT WORK? ❑YES❑NO		EMAIL:	
PERMISSION FOR RELEASE OF INFORMATION TO:			
EMERGENCY CONTACT NAME/NUMBER:		RELATIONSHIP:	

THE FOLLOWING INFORMATION WILL BE USED TO HELP PLAN SAFE AND EFFECTITVE MASSAGE SESSIONS. PLEASE ANSWER THE QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

HAVE YOU HAD A PROFESSIONAL MASSAGE BEFORE? ❑YES ❑NO
IF YES, HOW OFTEN DO YOU RECEIVE MASSAGE THERAPY AND WHAT TYPE (SWEDISH, DEEP TISSUE, CRANIOSACRAL, ETC.)? _____

DO YOU HAVE ANY DIFFICULTY LYING ON YOUR FRONT, BACK, OR SIDE? ❑YES ❑NO
IF YES, PLEASE EXPLAIN:

DO YOU HAVE ANY ALLERGIES TO OILS, LOTIONS, OR OINTMENTS? ❑YES ❑NO
IF YES, PLEASE EXPLAIN:

DO YOU HAVE SENSITIVE SKIN? ❑YES ❑NO

ARE YOU WEARING ANY OF THE FOLLOWING: ❑ CONTACT LENSES ❑ DENTURES ❑ A HEARING AID

DO YOU SIT FOR LONG HOURS AT A WORKSTATIONS, COMPUTER, OR DRIVING? ❑YES ❑NO
IF YES, PLEASE DESCRIBE:

DO YOU PERFORM ANY REPTITIVE MOVEMENT IN YOUR WORK, SPORTS, OR HOBBY? ❑YES ❑NO
IF YES, PLEASE DESCRIBE:

DO YOU EXPERIENCE STRESS IN YOUR WORK, FAMILY, OR OTHER ASPECT OF YOUR LIFE? ❑YES ❑NO
IF YES, DO YOU THINK IT HAS AFFECTED YOUR HEALTH AND HOW SO? ❑YES ❑NO
❑ MUSCLE TENSION ❑ ANXIETY ❑ INSOMNIA ❑ IRRITABILITY ❑OTHER: _____

IS THERE A PARTICULAR AREA OF THE BODY WHERE YOU ARE EXPERIENCING TENSION, STIFFNESS, PAIN OR OTHER DISCOMFORT? ❑YES ❑NO
IF YES, PLEASE IDENTIFY:

DO YOU HAVE ANY PARTICULAR GOALS IN MIND FOR THIS MASSAGE SESSION? ❑YES ❑NO
IF YES, PLEASE EXPLAIN:

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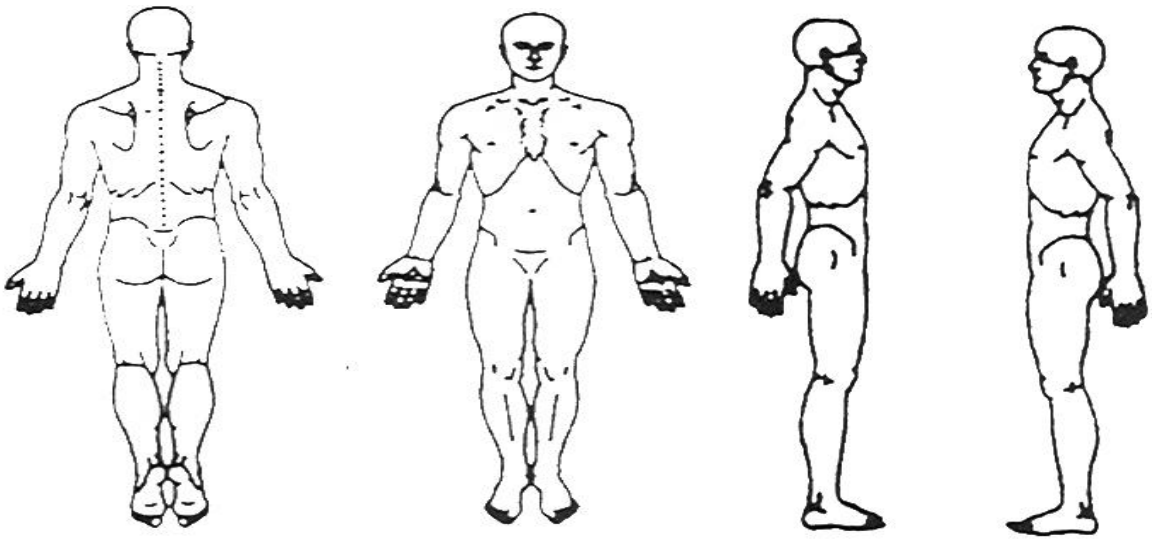
CIRCLE ANY SPECIFIC AREAS YOU WOULD LIKE THE MASSAGE THERAPIST TO CONCENTRATE ON DURING THE SESSION:



MEDICAL HISTORY
(In order to plan a massage session that is safe and effective. Some general information is needed about your medical history.)

ARE YOU CURRENTLY UNDER MEDICAL SUPERVISION? ❑YES ❑NO
IF YES, PLEASE EXPLAIN:

DO YOU SEE A CHIROPRACTOR? ❑YES ❑NO
IF YES, HOW OFTEN?

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? ❑YES ❑NO
IF YES, PLEASE LIST:

PLEASE CHECK ANY CONDITION LISTED BELOW THAT APPLIES TO YOU:

- ❑ CONTAGIOUS SKIN CONDITION
- ❑ OPEN SORES OR WOUNDS
- ❑ EASY BRUISING
- ❑ RECENT ACCIDENT OR INJURY
- ❑ WHIPLASH
- ❑ RECENT SURGERY
- ❑ ARTIFICIAL JOINT
- ❑ SEIZURES
- ❑ INSOMNIA
- ❑ SWOLLEN GLANDS
- ❑ HEPATITIS (A, B, C, OTHER)
- ❑ HEART CONDITION
- ❑ HIGH OR LOW BLOOD PRESSURE
- ❑ CIRCULATORY DISORDER
- ❑ VARCOSE VEINS / PHLEBITIS
- ❑ DEEP VEIN THROMBOSIS / BLOOD CLOTS
- ❑ EDEMA
- ❑ STROKE
- ❑ CONSTIPATION / DIARRHEA
- ❑ AUTO-IMMUNE CONDITION
- ❑ DEPRESSION, PANIC DISORDER, OR OTHER PYSCH CONDITION
- ❑ DIVERTICULITIS
- ❑ CHEMICAL DEPENDENCY (ALCOHOL, DRUGS)
- ❑ SCOLIOSIS
- ❑ SEIZURES
- ❑ EPILEPSY
- ❑ HEADACHES / MIGRAINES
- ❑ TMJ
- ❑ JOINT DISORDER / RHEUMATOID ARTHRITIS / OSTEOARTHRITIS / TENDONITIS
- ❑ OSTEOPOROSIS
- ❑ TENNIS ELBOW
- ❑ CARPAL TUNNEL SYNDROME
- ❑ CANCER
- ❑ DIABETES
- ❑ DECREASED SENSATION
- ❑ CHRONIC PAIN
- ❑ FIBROMYALGIA
- ❑ PREGNANCY (IF YES, HOW MANY MONTHS? ___)

PLEASE EXPLAIN ANY CONDITION THAT YOU HAVE MARKED ABOVE: _____
_____
_____
_____
_____
_____

ANYTHING ELSE ABOUT YOUR HEALTH HISTORY THAT YOU THINK WOULD BE USEFUL FOR YOUR MASSAGE THERAPIST TO KNOW TO PLAN A SAFE AND EFFECTIVE MASSAGE SESSION FOR YOU?_ _____
_____
_____

INFORMATION FOR YOU, THE CLIENT, TO HELP PLAN SAFE AND EFFECTIVE MASSAGE SESSIONS.

SCOPE OF PRACTICE

MASSAGE THERAPY IS NOT A SUBSTITUTE FOR MEDICAL TREATMENT OR MEDICATIONS. YOU ARE RECOMMENDED TO WORK CONCURRENTLY WITH YOUR PRIMARY CAREGIVER FOR ANY CONDITIONS YOU MAY HAVE. AS CERTIFIED AND LICENSED MASSAGE THERAPISTS, WE DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS, NOR DO WE PRESCRIBE MEDICATIONS. SPINAL MANIPULATIONS ARE NOT PART OF MASSAGE THERAPY. IF WE ARE UNABLE TO MEET YOUR HEALTH NEEDS, WE CAN GET REFERRALS FOR THE APPROPRIATE PROFFESSIONALS AVAILABLE. ALL BODYWORK AND MASSAGE THERAPY OFFERED IS STRICKLY NON-SEXUAL. ANY ILLICIT OR SEXUALLY SUGGESTIVE REMARKS OR ADVANCES WILL NOT BE TOLERATED AND WILL RESULT IN TERMINATION OF THIS AND FUTURE SESSIONS WITH NO REFUND OR CREDIT DUE ON ACCOUNT. IN ORDER TO RECEIVE THE MOST BENEFIT FROM YOUE MASSAGE, WE ADVISE YOU TO REFRAIN FROM CONSUMING ALCOHOL OR DRUGS, (PRESCRIPTION, OVER THE COUNTER, ETC.), 12 HOURS PRIOR TO YOUR SESSION.

CONFIDENTIALITY

IN ORDER TO CREATE A SAFE ENVIROMENT, ANYTHING YOU SHARE WITH US DURING A SESSION WILL BE HELD IN THE STRICTEST CONFIDENCE. PLEASE UNDERSTAND THIS DOES NOT MEAN WE WOULD ENCOURAGE ANY PERSONAL DISCUSSIONS OR TO SHARE ANY PSYCHOLOGICAL PROBLEMS. ALL HEALTH RELATED RECORDS ARE ALSO CONFIDENTIAL AND WILL ONLY BE RELEASED WITH YOUR WRITTEN CONCENT OR IF LEGALLY SUBPOENAED.

PRIVACY AND DRAPING

YOUR COMFORT AND SECURITY ARE OUR PRIMARY CONCERNS AND WE WILL RESPECT YOUR PRIVACY AT ALL TIMES. BEFORE GETTING ON THE TABLE, YOU CAN UNDRESS TO YOUR COMFORT. FEEL FREE TO LEAVE ON ANY CLOTHING YOU FEEL COMFORTABLE WITH. DURING THE SESSION YOU WILL BE COVERED WITH A SHEET (BLANKET PROVIDED UPON REQUEST) AND ONLY THE AREA BEING WORKED ON WILL BE UNCOVERED. AT NO TIME DURING THE SESSION SHOULD YOU REMOVE COVERING FROM YOU BODY FOR ANY REASON. YOUR THERAPIST WILL MOVE THE COVERING AS NEEDED PER THE CURRENT WORK REQUIREMENTS. CLIENT REMOVAL OF COVERING WILL RESULT IN TERMINATION AS STATED UNDER SECTION SCOPE OF PRACTICE. IF YOU HAVE ANY SPECIFIC QUESTIONS OR REQUESTS, YOU ARE ENCOURAGED TO COMMUNICATE THEM TO YOUR THERAPIST AT ANYTIME BEFORE, DURING OR AFTER THE SESSION.

CLEANLINESS

IN ORDER TO MAINTAIN A HEALTHY WORKING ENVIROMENT, WE REQUEST THAT YOU COME PREPARED FOR THE SESSION WITH A CLEAN BODY, AS OUR STAFF WILL RETURN THE SAME COURTESY. ALL EQUIPMENT IS CLEANED AFTER EACH USE.

PAYMENT

PAYMENT IS DUE PRIOR TO THE BEGINNING OF THE SESSION. CASH, CHECK, CREDIT CARD AND GIFT CERTIFIACTES ARE ALL ACCEPTED FOR PAYMENT. SHOULD A CHECK BOUNCE YOU WILL BE CHARGED AN ADDITIONAL $40 FEE AND WILL BE PROHIBITED FROM WRITING FUTURE CHECKS. ALL UNPAID APPOINTMENTS WILL BE SECURED WITH A CREDIT CARD ON FILE. THIS CARD WILL ONLY BE CHARGED IF CANCELLATION POLICY IS NOT MET.

LATE ARRIVALS AND CANCELLATIONS

IN ORDER TO RECEIVE YOUR FULL SESSION WE ASK YOU ARRIVE FOR YOUR APPOINTMENT ON TIME. FOR LATE ARRIVALS THE SESSION WILL END AT THE SCHEDULED TIME AND FULL PAYMENT IS EXPECTED. A 24-HOUR CANCELLATION NOTICE IS APPRECIATED. PAYMENTS FOR CANCELLATIONS WITH LESS THAN 24-HOUR NOTIFICATION ARE LEFT AT THE DISCRETION OF CLINIC. WITH ANY CANCELLATIONS, FUTURE APOINTMENTS MAY NEED TO BE PAID IN FULL, AT THE TIME OF SCHEDULING. IT IS YOUR RIGHT TO TERMINATE THE SESSION AT ANY POINT FOR ANY REASON. TERMINATION OF THE SESSION DOES NOT ENTITLE CLIENT TO CREDIT OR REFUND.

RELEASE

BECAUSE MASSAGE THERAPY SHOULD NOT BE PREFORMED UNDER CERTAIN CONDITIONS, I AFFIRM THAT I HAVE STATED ALL MY MEDICAL CONDITIONS AND ANSWERED ALL QUESTIONS HONESTLY. I AGREE TO KEEP THE THERAPIST AND CLINIC UPDATED AS TO ANY CHANGES IN MY MEDICAL PROFILE AND UNDERSTAND THAT THERE SHALL BE NO LIABLITY ON THE THERAPIST/CLINIC'S PART SHOULD I FAIL TO DO SO. BY SIGNING THIS FORM, I HEREBY WAIVE AND RELEASE THE CLINIC, ANY MASSAGE THERAPIST AND STAFF MEMBER FROM ANY AND ALL LIABLITY, PAST, PRESENT AND FUTURE, RELATING TO MASSAGE THERAPY AND BODYWORK. I HAVE READ, UNDERSTAND AND AGREE TO ALL THE ABOVE STATEMENTS AND POLICIES THEREIN.

CLIENT SIGNATURE: _____DATE: _____

PRINTED NAME: _____

Sunrinity Health

Sunrinity Health does not allow cell phone usage in the office. We ask that while you are here, you leave your cell phone in your vehicle or turn it off prior to entering the office.

We understand cell phones have become a huge part of how we as a society operate daily and it is hard for most people to unplug. It is vital that you unplug during your sessions however. We do our best to be courteous of your time and ask that you return the favor. We have had an increasing amount of people using their phones before, during and after their sessions. This is disruptive to your therapy, your therapist and other clients.

1. If you're not unplugged you are not allowing your body and mind to receive the full benefits of the therapy.
2. Your usage takes from your session time and other clients.
3. Using your phone during the session, yes even texting, positions your muscles out of alignment needed to receive massage and could potentially become a hazard for you and/or your therapist.

We ask that if it is not possible for you to turn your cell phone off for the duration of your visit, please schedule another time that you are able to turn it off. (Cancellation policy will be considered)

Should your phone or any other device vibrate, ring or be used while you are in the office, your session maybe terminated immediately without a refund.

Thank you for your understand and cooperation in this matter.

I have read and understand all terms stated above.

_____ _____

Signature Date

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