Bel-Ray Wellness Center

CONFIDENTIAL

MASSAGE THERAPY INTAKE

PERSONAL INFORMATION

First Name: _____ MI: _____ Last Name: _____

Home Address: _____ City: _____ State: ___ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Text Reminders Y N Cell Carrier:_____

Occupation: _____

Date of Birth: _____ Age: _____

For insurance purposes sex assigned at birth: Male Female

Circle the group of personal pronouns you identify by: He,His,Him/She,Her,Hers/They,Theirs,Them

Other: _____

Email address for educational info & clinic announcements: _____

Who referred you to our clinic? _____

CURRENT HEALTH

Have you had a professional massage before? Yes No
If yes, how often do you receive massage therapy and type? _____
Do you have any difficulty lying on your front, back, or side? Yes No
If yes, please explain _____
Do you have any allergies/sensitive skin to oils, lotions, or ointments? Yes No
If yes, please explain _____
Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please describe _____
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 _____
Are you pregnant? Yes No What week?_____ Any challenges?_____
If yes, who is your OB?_____ Have you spoken to them about receiving massage? Yes No

MEDICAL HISTORY

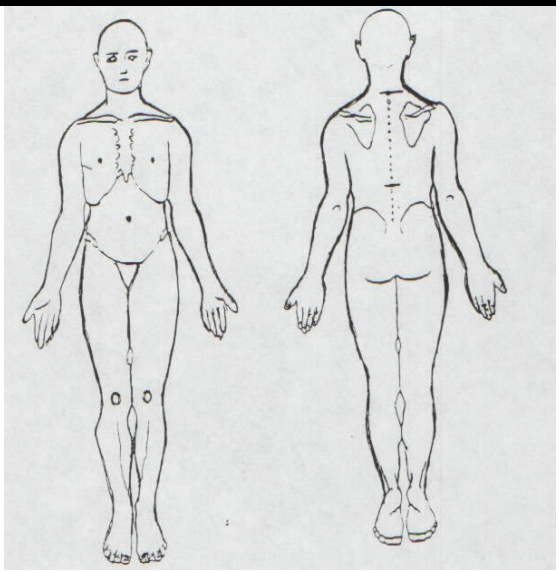
Are you currently under a doctor or therapists supervision? Yes No
If yes, please explain _____
Do you see a chiropractor? Yes No If yes, how often?_____
Are you currently taking any medication? Yes No
If yes, please list_____
Please check any condition listed below that applies to you:

( ) Allergies
( ) Asthma
( ) Blood Clots
( ) Broken/Fractured Bones
( ) Cancer
Specify _____
( ) Diabetes
( ) Edema
( ) Fibromyalgia
( ) Headaches
( ) Heart Disease/Attack
( ) High/Low Blood Pressure
( ) Jaw Pain (TMJ)
( ) Lymph Node Removal
Specify_____
( ) Numbness
( ) Osteoarthritis
( ) Osteoporosis/Osteopenia
( ) Rheumatoid Arthritis
( ) Sciatica
( ) Skin Disorders
( ) Slipped/Degenerative/Fused Disc
( ) Tendon/Ligament/Tear
( ) Varicose Veins

Please explain any condition that you have marked above_____
Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?_____

BODY MAP

Please complete the body map using the symbols below.
P— Area(s) where you are experiencing pain.
X— Area(s) that are tight.
T— Area(s) that are ticklish.



The following sometimes occurs during massage; these are a few of the normal responses to relaxation. Trust your body to express what it needs to: a need to move or change position * sighing * yawning * change in breathing * stomach gurgling * emotional feelings and/or expression * movement of intestinal gas * energy shifts * falling asleep *

RELEASE

Please read carefully and sign below.

1. I understand that the massage/body work I receive is provided for the basic purpose 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 also may request that the session be discontinued at any time, for any reason, and the therapist will honor that request.
2. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a chiropractor, physician or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork therapists are not qualified to perform spinal or skeletal adjustments, diagnose , prescribe, or treat any physical or mental illness, and nothing said in the course of the session given should be construed as such.
3. Due to the fact that massage/bodywork should not be performed under certain medical conditions, 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 there shall be no liability on the therapist's part should I fail to do so.
4. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled massage. appointment.

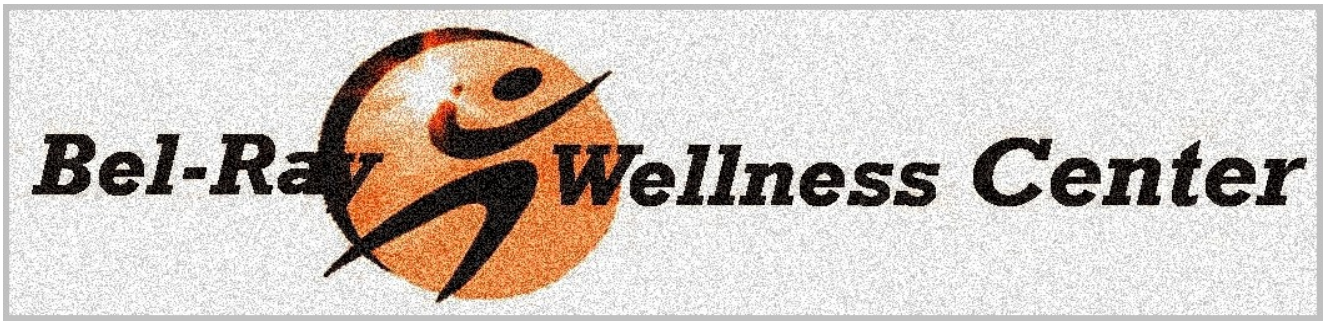
I give my permission to have massage techniques applied to my person.

Signature _____ Date _____

Therapist _____ Date _____

Consent to Treatment of Minor: By signing below, I hereby authorize the LMT to administer massage or bodywork techniques to my child or dependent as he deems necessary.

Signature of Parent/Guardian _____ Date _____



24 Hour Appointment Cancellation Policy

Bel-Ray Wellness Center has a 24 hour cancellation / rescheduling policy.

If you miss your appointment, cancel or change your appointment with less than 24 hours notice, you will be charged HALF price of the massage.

This policy is in place out of respect for our therapists and our clients. Cancellations with less than 24 hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Bel-Ray Wellness Center as described above.
Thank you for your understanding and cooperation.

Massage Expiration Policy

Any massage purchased, single or 4 packs, will expire one year from date of purchase. Massages not used within one year from purchase date will be forfeited.

_____ _____

Patient Name (printed) Patient/Guardian Signature

_____

Date