Client Intake Form

Please fill out all information as accurately and thoroughly as possible.

A VALLEY of VITALITY
WELLNESS STUDIO

Name:_____ Date of Birth_____
Address:_____ Occupation_____
City:_____State_____Zip_____ Activities_____
Home Phone_____ Emergency Contact Name_____
Cell Phone_____ Emergency Contact Phone_____
Email Address_____
How did you discover us? (circle one) Internet Facebook Yelp Ad Referral – who?_____
Other_____
Have you ever received massage or bodywork before? ❑ Yes ❑ No, If yes, was it effective?_____
What specifically would you like to receive from this massage?_____
Would you like us to **focus** on or **stay away** from any specific area?_____
Please indicate your desired level of pressure.

❑ Light ❑ Medium ❑ Deep

HEALTH INFORMATION

Do you have any of the following? Please check Yes or No. If yes, please explain as clearly as possible.

❑ Yes ❑ No Do you frequently suffer from stress?
❑ Yes ❑ No Have you had any recent injuries?
Please Describe: _____
❑ Yes ❑ No Do you have diabetes? If "Yes", are you insulin dependent? ❑ Yes ❑ No
❑ Yes ❑ No Do you experience frequent headaches?
❑ Yes ❑ No Are you pregnant?
❑ Yes ❑ No Do you suffer from arthritis or joint swelling?
❑ Yes ❑ No Are you wearing contact lenses or hearing aids?
❑ Yes ❑ No Are you wearing dentures?
❑ Yes ❑ No Do you have high blood pressure?
❑ Yes ❑ No Are you taking high blood pressure meds?
❑ Yes ❑ No Do you have any cardiac or circulatory problems?
❑ Yes ❑ No Do have a pacemaker or internal defibrillator?
❑ Yes ❑ No Do you suffer from epilepsy or seizures?
❑ Yes ❑ No Do you have varicose or spider veins?
❑ Yes ❑ No Do you have any contagious diseases?
❑ Yes ❑ No Do you have osteopenia or osteoporosis?
❑ Yes ❑ No Do you have any allergies?
❑ Yes ❑ No Do you bruise easily?
❑ Yes ❑ No Are you taking blood-thinning medication?
❑ Yes ❑ No Have you had any broken bones in the past 2 years?
❑ Yes ❑ No Do you have tension or soreness in a specific area?
Please specify: _____
❑ Yes ❑ No Do you suffer from back pain?
❑ Yes ❑ No Do you have numbness or stabbing pains?
❑ Yes ❑ No Are you sensitive to touch or pressure in any area?
❑ Yes ❑ No Have you ever had any surgeries?
Please Describe: _____
❑ Yes ❑ No Are you under physician's care for a specific condition?
❑ Yes ❑ No Other medical conditions, or medications we should know about?_____
❑ Yes ❑ No Do you have any conditions that may require a doctor's note?
❑ Yes ❑ No Is it okay for us to contact your health care provider if necessary? If Yes, please provide contact info
Physician Name_____, #_____
Other Health Conditions:_____
_____

***If you need more space, please use the back side of this form.**

Please Read and Sign Below:
SCOPE OF MASSAGE, BODYWORK, and Cupping/Gua Sha Treatment

I understand that the massage/bodywork 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 practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. 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 physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness and that nothing said in the course of the session given should be construed as such. Because 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. Information has been provided to me either verbally or in written form about my services I'll be receiving and I understand the potential effects and aftercare recommendations. 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 full payment of the scheduled appointment.

Please Read and Sign Below:
SPECIFIC MEDICAL CONDITIONS

For your safety, the therapist must be aware of all medical conditions. For which you have been diagnosed. Massage, bodywork/treatments may impact your health. I have completed this form to the best of my knowledge and will inform the therapist of any future changes in my health between massage appointments. I understand that a massage therapist cannot diagnose illness, disease, or any other medical, physical, emotional disorders. I understand that if I arrive late, my session will end at the originally scheduled time to avoid schedule conflicts. I agree to give a **24-hour** notice for a schedule session that I cannot keep to avoid paying a **$30 late fee**.

Cancellation Policy: *Emergencies do occur; however, in order to be available to clients who would like to be seen by appointment, we request that you notify us with a minimum of **24-hours** if you need to cancel or reschedule an appointment. No-Shows and same-day cancellations less than **24 hours** will be charged a **$30 late/cancellation fee**. If paying by gift card, this fee will be deducted from the gift card number provided. If no gift card number was provided, the fee will be charged to your account. If your account has a negative balance, we cannot accept future bookings until you come current with your account.*

I verify that all information is correct and current to the best of my knowledge. I understand that any information provided is for safety purposes and will be kept strictly confidential, I hereby give my consent to receive massage services and/or other bodywork or treatment.

I have read and understand the above:

_____ _____
Client or Legal Guardian Signature Date

_____ _____
Practitioner Date