Body First

2020 Client Intake Form- Massage Therapy

Last Name First Name M.I.

Address:

City State Zip

Occupation:

Work Phone: Home Phone: Cell Phone:

Date of Birth Today's Date:

Email Address:

Please check any Body First Programs you are interested in receiving information about.

☐ Massage Therapy ☐ Personal Training ☐ Fitness ☐ Membership
☐ Running ☐ Yoga ☐ Adult Tennis ☐ Youth Tennis
☐ other:

Name of Person who referred you?

MASSAGE INFORMATION

Have you ever had a professional massage before? **Y N**

If yes, how often do you receive massage therapy?

What types of massage are you seeking today?
(check as many that apply.)

☐ Relaxation ☐ Deep Tissue/ Therapeutic
☐ Sports Massage ☐ Pregnancy
Sport: How many months?
☐ Other:

What is your goal for today's Massage?

What kind of pressure do you prefer?

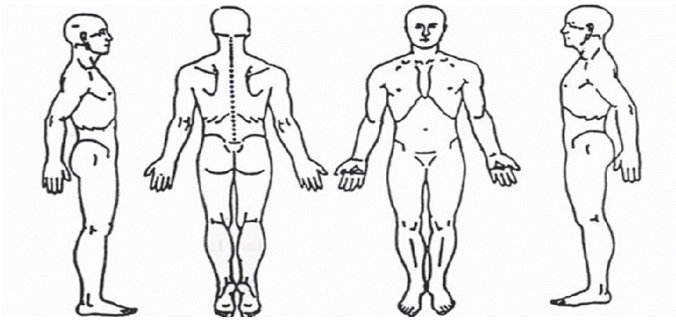
Very Deep **Deep** **Firm** **Gentle** **Extra Gentle** **Not Sure**

Do you have any difficulty lying on your back, front, or side? **Y N**
If yes please explain:

Do you have any allergies to oils or lotions or sensitive skin? **Y N**
If yes please explain:

What are your current complaints?

On the chart below please mark any areas where you



are having muscle pain/tension.

HEALTH HISTORY

Do you suffer from persistent pain or discomfort? **Y N**
If so, for how long?_____
Do you know what caused it or when the symptoms seem to get better or worse?
Do you see a chiropractor?_____
If so, how often? _____
Are you currently on Aspirin Therapy or taking any other blood thinners? _____
Are you on any additional medications the therapist should be aware of? If so, what?

Please mark the conditions you are experiencing now or have in the past.

☐ Aids/ HIV ☐ Allergies
☐ Arthritis ☐ Asthma
☐ Back Pain ☐ Blood clots
☐ Bursitis ☐ Bruise Easily
☐ Chronic Fatigue ☐ Cancer/Tumors
☐ Diabetes ☐ Chronic Pain
☐ Headaches/migraines ☐ Dizziness
☐ High blood pressure ☐ Heart disease/ Stroke
☐ Major accident ☐ Leg pain
☐ Muscle/ joint problems ☐ Neck pain
☐ Pregnancy(Due Date:_____) ☐ Numbness
☐ Sinusitis ☐ Sciatica
☐ Recent surgeries: ☐ Skin conditions
☐ Varicose veins ☐ other:

Please explain any conditions listed above

BODY FIRST

Please take a moment to read and initial the following statements and sign below where indicated.

____ **Massage Therapy for wellness.** I understand that the services I receive is provided for the purpose of wellness and body maintenance and services may include modalities that are designed to enhance physical fitness, mental attitudes, and alertness.

____**Client Health Warranty** I am not aware of any disability, impairment, or ailment preventing me from receiving massage therapy. I affirm that I have stated all my known medical conditions and injuries and answered all questions honestly. I agree to keep the massage therapists updated as to any changes in my health profile, and understand that there shall not be liability on the massage therapist's part should I forget to do so.

____**Massage Therapist role in client wellness.** I understand that massage therapists are not qualified to diagnose or prescribe for disease conditions and that nothing said, done, performed, typed, printed or produced is intended or meant to diagnose, prescribe, treat a disease or takes the place of a licensed physician, chiropractor, registered dietitian or other qualified health professional. I understand that body maintenance assessments and suggestions are intended only for the support of optimal health and do not involve diagnosing, prognosticating, or prescribing any remedies for the treatment of disease conditions.

___**Client responsibility for their wellness.** I understand that I accept total responsibility for my own health care and maintenance and that I should seek treatment from a physician, chiropractor, registered dietitian or other qualified medical specialist for any medical conditions that I am aware of.

___**Clients right to manage their massage therapy session.** If I experience any pain or discomfort, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort.

___**Therapist's right to refuse service**. I understand that the therapist may choose to end any massage therapy session if they believe massage therapy could be detrimental to the client, the client is under the influence of drugs or alcohol, or the client exhibits any inappropriate behavior towards the therapist.

___ **Professional Draping.** For all services that require the client to undress; professional draping will be used during the session.

___ **Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19** The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to The virus that causes COVID-19 is spreading from person-to-person. People are thought to be most contagious when they are symptomatic (the sickest). (1). [1]As a result, federal, state, and local governments and federal and state health agencies recommend social distancing, wearing a mask, and have, in many locations, prohibited the congregation of groups of people. Body First ("Body First") has put in place preventative measures to reduce the spread of COVID-19; however, Body First LLC cannot guarantee that you or your child(ren)will not become infected with COVID-19. Further, visiting Body First Wellness and Recreation Center; receiving Body First services, including but not limited to massage therapy, personal training, and tennis lessons; or utilizing the Body First Fitness areas and equipment could increase your risk and your child(ren)'s risk of contracting COVID-19. By agreeing, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I or my child(ren) may be exposed too

I hereby affirm that I have read, fully understand and therefore consent to participating with *Body First* in programs and services within the framework stated above.

Client Signature: _____ Date: _____

Print Name: _____

Consent for treatment to minor: I hereby authorize Body First to administer massage therapy and/or body work services to my child or dependent as they deem necessary.

Date

Parent/Guardian Signature: _____

Parent/Guardian Print Name _____

[1] Content source: National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases, Center for Disease Control and Prevention; Coronavirus Disease 2019 (COVID-19); Frequently asked Questions; https://www.cdc.gov/coronavirus/2019-ncov/faq.html (Page last reviewed: May 29, 2020)