



Client Intake Form

Personal Contact Information

FULL NAME

OCCUPATION

PHONE (DAY)

PHONE (EVENING)

ADDRESS

ADDRESS (CITY / STATE / ZIP)

EMAIL

DATE OF BIRTH

EMERGENCY CONTACT (NAME)

EMERGENCY CONTACT (PHONE)

The following information will be used to help plan safe and effective massage therapy sessions. Please answer the questions to the best of your knowledge.

Date of Initial Visit

Have you had a professional
massage before?

☐ YES ☐ NO

If yes, how often do you receive massage therapy?

Type of massage experienced? (Swedish, Shiatsu, Deep Tissue, 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...

☐ Contact Lenses ☐ Dentures ☐ Hearing Aid

☐ Hairpiece

Do you sit for long hours at a workstation, computer, or driving?

☐ YES ☐ NO

If yes, please describe:

Do you perform any repetitive 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, how do you think it has affected your health?

- ☐ 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:

Are you currently taking any medications?

- ☐ YES ☐ NO

If yes, please list name and reason for medications:

Are you currently seeing a healthcare professional?

- ☐ YES ☐ NO

If yes, please list name(s) and reason/treatment:

Please review this list and check those conditions that have affected your health either recently or in the past.

- | | |
|--|--|
| ☐ Arthritis | ☐ Auto-Immune Condition* |
| ☐ Back Problems | ☐ Blood Clots |
| ☐ Broken/Dislocated Bones | ☐ Bruise Easily |
| ☐ Cancer | ☐ Chemical Dependency (drugs/alcohol) |
| ☐ Chronic Pain | ☐ Constipation/Diarrhea |
| ☐ Depression, Panic Disorder, Other | ☐ Diabetes |
| ☐ Diverticulitis | ☐ Headaches |
| ☐ Heart Conditions | ☐ Hepatitis (A, B, C, other) |
| ☐ High Blood Pressure | ☐ Insomnia |
| ☐ Muscle Strain/Sprain | ☐ Pregnancy |
| ☐ Scoliosis | ☐ Seizures |
| ☐ Skin Conditions | ☐ Stroke |
| ☐ Surgery | ☐ TMJ |
| ☐ Whiplash | ☐ Other |

(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

If any of the above needs to be detailed, or if there is anything else to share, please do so:

Do you have any of the following today?

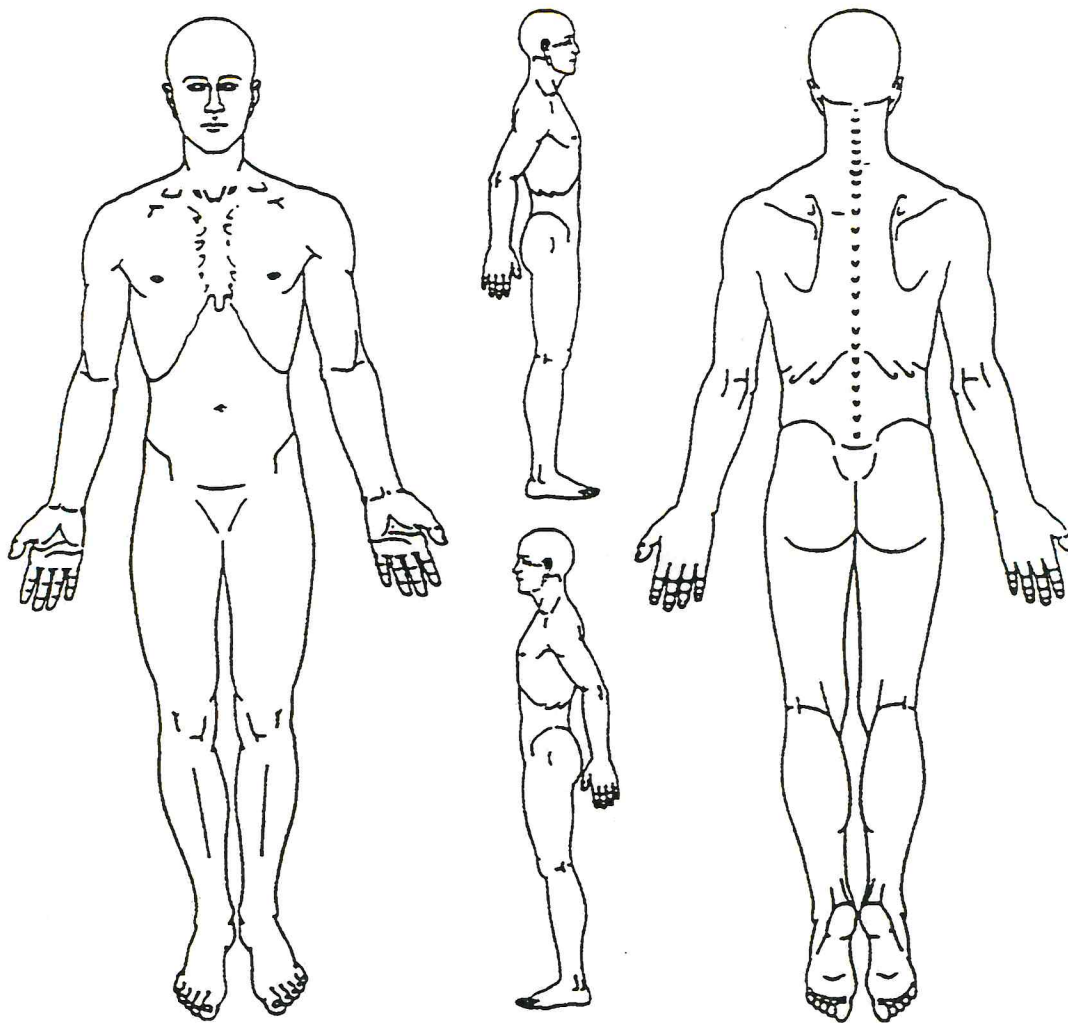
- | | | |
|--------------------------------------|--|---|
| ☐ Skin Rash | ☐ Cold/Flu | ☐ Open Cuts |
| ☐ Severe Pain | ☐ Anything Contagious | ☐ Injuries/Bruises |

Do you have any allergies to:

- | | |
|---|--|
| ☐ Medications | ☐ Foods (nuts, etc.) |
| ☐ Environmental Allergens (dust, etc.) | ☐ Reactions to Skin Care Products |

If any of the above are checked, please provide details:

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



What are your goals / expectations for this therapy session?

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to:

- ~ 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 ~ memories ~



Informed Consent & Wavier

Massage Patient Information & Informed Consent Form

1. I understand that massage therapists, body workers, and holistic practitioners are not medical doctors and do not diagnose illness, disease, or any physical or mental disorder. I acknowledge that massage and alternative holistic therapies are not substitutes for medical treatment, and that Flow Massage Therapy LLC, ("Flow"), recommends I see a primary healthcare provider for medical services. I understand that it is my responsibility to communicate with my therapist if I have concerns or questions about my session. I do not have any injuries or conditions that would prevent me from receiving a massage, nor have I been told by a health care provider that I should not receive massages or alternative therapies.
2. I understand that massage therapy and body work services are a therapeutic health aid and are non-sexual. I understand my massage therapist reserves the right to end a therapy session in the case of sexual innuendo or advances from the client. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the massage, and I will be liable for full payment of the scheduled session.
3. Any information exchanged during a massage or body work session is confidential and is only used to provide me with the best health care services available. I understand that a massage therapist will ask me questions about my health and physical condition and that I am obligated to answer truthfully and honestly about my health history in full detail.
4. I understand that my feedback is essential in my treatment, and that if I experience any unusual discomfort and/or pain during my massage session, it is my responsibility to inform the therapist in order to enable the therapist to adjust the pressure or technique being used.
5. The therapist reserves the right to decline, discontinue, or restrict services based on any provided information that may indicate that massage therapy would put my health or the therapist's health at risk.
6. I acknowledge that I am responsible to be on time for my appointments and that the therapist is not under any obligation to extend my therapy session. I also agree that I am responsible to pay for the full time I have booked with the therapist if I am late. I understand that my appointment time is reserved for me only. If I miss an appointment or am unable to give twenty-four (24) hours' notice when I need to change or cancel my appointment, I agree to pay Flow in full for the booked appointment time. I further understand that I will be charged an additional thirty dollars (\$30.00) for any returned checks.
7. I understand that massage therapy and body work are for the purposes of stress reduction, relief from muscular tension and spasm, general relaxation and improvement of circulation and energy flow.
8. I understand that the massage therapist practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations.
9. I understand that service offered today, and in the future, are not a substitute for medical care and that any information provided to me by the therapist is purely for educational purposes and is not diagnostically prescriptive in nature.
10. I have stated all of my known medical conditions on the Client Intake form. I have consulted a medical doctor or licensed medical health care practitioner regarding any checked or described conditions.
11. I understand that it is solely my responsibility to keep the therapist updated on any changes in my physical health and I further understand that Flow and the therapist shall not be liable for any reason whatsoever, should I fail keep the therapist updated on any changes in my physical health.
12. I have reviewed this form in its entirety and I have discussed all my concerns regarding my treatment with my therapist.

ACKNOWLEDGEMENT

CLIENT:

By signing this "Informed Consent and Waiver", I consent to receive therapy by Flow Massage Therapy LLC, and hereby agree to all policies of Flow Massage Therapy LLC, and waive and release Flow Massage Therapy LLC and its entire staff, massage therapists, and body work practitioners from any and all past, present, and future liability, loss, cost, claim, or damage whatsoever which may be imposed upon Flow Massage Therapy LLC relating to massage therapy and body work; including, but not limited to, reflexology, acupressure, polarity therapy, energy therapy, Reiki, nutritional therapies, all forms of kinesiology, aromatherapy, craniosacral therapy, myofascial release therapy, trigger point therapy, stretching therapy, strength and condition training, among others. I further undertake to indemnify and hold Flow Massage Therapy LLC harmless from any accident(s) arising from my use of Flow Massage Therapy LLC's services.

I agree to and acknowledge the foregoing on this _____ day of _____, 20__.

(Signature)

(Printed Name)

(Street Address)

(City/State/Zip)

(Telephone Number)

Are you under the age of 18?

☐ Yes

☐ No

PARENT/GUARDIAN WAIVER FOR MINORS:

If the client is less than 18 years old, the Client's parent and natural guardian hereby represents that he/she is, in fact, acting in that capacity, has consented to his/her child or ward's availing of the services of Flow Massage Therapy LLC, and has agreed individually and on behalf of the child or ward, to the terms of this "Informed Consent and Waiver". The undersigned parent or guardian further agrees to save and hold harmless and indemnify Flow Massage Therapy LLC from all liability, loss, cost, claim or damage whatsoever which may be imposed upon Flow Massage Therapy LLC relating to massage therapy and body work; including, but not limited to, reflexology, acupressure, polarity therapy, energy therapy, Reiki, nutritional therapies, all forms of kinesiology, aromatherapy, craniosacral therapy, myofascial release therapy, trigger point therapy, stretching therapy, strength and condition training, among others, on behalf of the Client and all of the Client's parents or legal guardians.

I agree to and acknowledge the foregoing on this _____ day of _____, 20__.

(Signature)

(Printed Name)

(Street Address)

(City/State/Zip)

(Telephone Number)

Cancellation Policy

I understand that each appointment I have is very important either for my own treatment process or that of another who could potentially fill the time slot. I agree to notify Flow Massage Therapy LLC within 24 hours. If I am unable to do so, I understand that I will be responsible for the payment for the scheduled time, unless it can be filled by another.

I have read and understand this cancellation policy.

Signature

Date

COVID-19 Health Information & Informed Consent

Client Name: _____

Date: _____

This document contains important information about your decision to receive services in light of the COVID-19 public health crisis. Please read and fill out this form carefully and let me know if you have any questions.

COVID-19 Information

Have you been tested for COVID-19? ☐ Yes ☐ No
If yes, what type of test did you have?

When was your test? _____

What were the results? _____

Please answer these COVID-19 health questions below:

1. Have you had a fever in the last 24 hours of 100°F or above?

☐ Yes ☐ No

2. Do you now, or have you recently had, any respiratory or flu symptoms (including fever, chills, sore throat, cough, muscle aches, or shortness of breath)?

☐ Yes ☐ No

3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms?

☐ Yes ☐ No

4. Have you traveled anywhere outside of the state in the last two weeks?

☐ Yes ☐ No

Location: _____

5. Have you had a new loss of sense of taste or smell? ☐ Yes ☐ No

The following questions are specific to a new aspect of COVID-19 involving blood coagulation.

6. Can you exercise to get your heart rate and respiratory rate up without any problem?

☐ Yes ☐ No

7. Have you had a new onset of muscle aches and pain since the emergence of the virus?

☐ Yes ☐ No

8. Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin?

☐ Yes ☐ No

Current Temperature: _____

☐ Used a no-contact thermometer to assess client.

Consent for Treatment

To proceed with receiving care, I confirm and understand the following (Initial in all places provided)

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. _____

I understand that I am the decision maker for my health care. To the best of their ability, my practitioner will provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult. _____

I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____

I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

I understand that close contact with people increases the risk of infection from COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage from this practitioner.

I understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____