

Client Intake, Policies & Procedures Form

Amyable Massage, LLC

Amy L. Bogart, LMT, RM, CCT, BCTM

Name: _____

Address: _____ City/State/Zip: _____

Birthdate: _____ Occupation: _____

Phone Number: _____ E-mail: _____

Emergency Contact (Name and phone): _____

Are you 18 yrs of age or older? Yes / No *If no parental consent section must be completed prior to services.

Reason for visit: _____

Please help me ensure a safe and comfortable massage experience by providing the following information.

Check any that apply to your health history:

- | | | |
|---|--|---|
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Strokes | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Infections | <input type="checkbox"/> Autoimmune diseases | <input type="checkbox"/> Migranes |
| <input type="checkbox"/> Thyroid issues | <input type="checkbox"/> Heart issues | <input type="checkbox"/> Osteoarthritis |

Any other illnesses: _____

Please list all medications: _____

List and explain any *recent* medical procedures: _____

Allergies(animals, scents, foods, seasonal?): _____

Any current skin conditions(bruises, rashes, acne?): _____

Have you ever received a professional massage before?: Yes No

Is there anything else you would like your therapist to know?: _____

(OVER -complete other side)

Policies & Procedures Statements:

I understand massage is provided for the basic purpose of relaxation and relief of muscular tension or spasm or to increase circulation. If I experience any pain or discomfort during treatment, I will immediately inform the therapist so that pressure and/or strokes may be adjusted to my level of comfort.

I understand that massage should NOT be construed as a substitute for medical examination or diagnosis. Massage therapists are not qualified to make spinal or skeletal adjustments, however, manipulation of muscles and soft tissue may indirectly affect the skeleton and spine.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all question honestly and completely. I agree to keep therapist updated to any changes in my medical profile and understand that there shall be no liability on the therapists part should I fail to do so.

I understand that treatment will not be given if I am under the influence of drugs or alcohol and it is my responsibility to inform my therapist of any drug or alcohol use prior to each treatment.

I understand any illicit or sexual behavior, advances, comments or remarks made by me will result in immediate termination of he session and I will be liable for full payment of the scheduled session.

I understand that if I request/agree to the use of cupping therapy I am aware there is the possibility that discolorations can occur from release of stagnation and toxins from my body and these discolorations will dissipate from a few hours to as long as 2 weeks in some cases.

CANCELLATIONS: Should I cancel an appointment less than 48 hours before scheduled time, "no show", or cancel appointments excessively (subject to therapists' discretion) I am subject to a fee equal to the cost of originally booked booked appointment. If appointment was booked to redeem a gift certificate it will be voided in lieu of the fee. Exceptions for emergencies will be at the therapist's discretion. Work will not be considered an emergency.

Payment is expected at the time service is rendered. Gratuities are left to the discretion of the client. Acceptable payment methods are cash, check, and all major credit cards.

By signing below I agree that I not only have read and agree to all the terms of the Client Policies & Procedures Statements listed, I also affirm that I have stated all known medical conditions and answered all questions honestly throughout this form.

(Print-Client Name)

(Sign-Client Name)

(Date)

Informed parental consent for a minor

By my signature below, I authorize massage treatments or bodywork to be administered to the minor listed on the first page.

(Print-Parent/Guardian Name)

(Sign-Parent/Guardian Name)

(Date)