Client Intake Form

ABOVE THE SKY
HOLISTIC MASSAGE

Personal Information:

Name _____ Phone (Day) _____ Phone (Eve) _____

Address _____

City/State/Zip _____

email _____ Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

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

Date of Initial Visit _____

1. Have you had a professional massage before? Yes No

   If yes, how often do you receive massage therapy? _____

2. Do you have any difficulty lying on your front, back, or side? Yes No

   If yes, please explain _____

3. Do you have any allergies to oils, lotions, or ointments? Yes No

   If yes, please explain _____

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( ) ?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No

   If yes, please describe _____

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No

   If yes, please describe _____

8. 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 _____

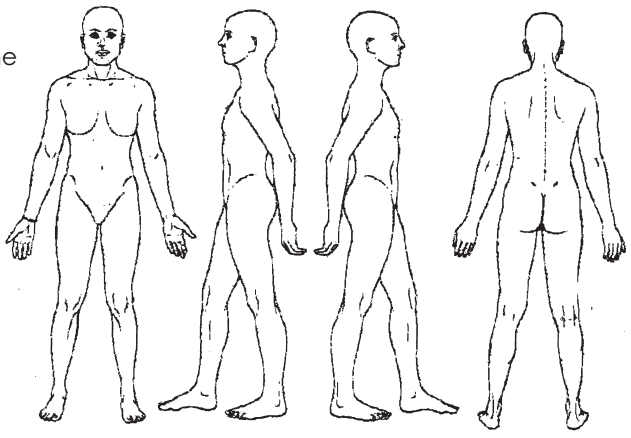
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

   If yes, please identify _____

10. Do you have any particular goals in mind for this massage session? Yes No

    If yes, please explain _____

Circle any specific areas you would like the massage therapist to concentrate on during the session:



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Medical History

In order to plan a massage session that is safe and effective, please provide some general information about your medical history.

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11. Are you currently under medical supervision? Yes No
If yes, please explain _____

12. Do you see a chiropractor? Yes No If yes, how often? _____

13. Are you currently taking any medication? Yes No
If yes, please list _____

14. Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) atherosclerosis
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder/rheumatoid arthritis/osteoarthritis
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) Fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) pregnancy If yes, how many months?
( ) feeling feverish
( ) measured temperature greater than or equal to 100°F
( ) cough
( ) shortness of breath
( ) chills
( ) repeated shaking with chills
( ) muscle pain
( ) sore throat
( ) loss of taste or smell
( ) diarrhea

Please explain any condition that you have marked above _____

_____

_____

15. 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? _____

_____

Draping will be used during the session – only the area being worked on will be uncovered.
Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session.
Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____ (print name) understand that the massage 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 therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 that I am aware of. I understand that massage therapists 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 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 that there shall be no liability on the therapist's part should I fail to do so.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____

INFORMED CONSENT AND WAIVER

1. I understand that massage 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 Above the Sky Holistic Massage, "the company", recommends I see a primary healthcare provider for that service. 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 the company in full for the booked appointment time. I further understand that I will be additionally charged $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 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 self-screened for and confirm that I am not exhibiting any of the following new or worsening signs or symptoms of possible COVID-19: Cough, shortness of breath or difficulty breathing, chills, repeated shaking with chills, muscle pain, sore throat, loss of taste or smell, diarrhea, feeling feverish or a measured temperature greater than or equal to 100° Fahrenheit, known or close contact with a person who is lab confirmed to have COVID-19. Furthermore, I understand that individuals aged 65 or older are at a higher risk of COVID-19.

11. 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.

12. 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 the company and the therapist shall not be liable for any purpose and for any reason whatsoever, should I fail to do the needful as per this paragraph.

13. I have reviewed this form in its entirety and I have discussed all my concerns regarding my treatment with my therapist.

ACKNOWLEDGEMENT SECTION

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CLIENT:

By signing this "Informed Consent and Waiver", I consent to receive therapy at Above the Sky Holistic Massage and hereby agree to all policies of Above the Sky Holistic Massage, and waive and release Above the Sky Holistic Massage 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 the Company 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 Above the Sky Holistic Massage harmless from any incident(s) arising from my use of the Above the Sky Holistic Massage's services.

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

_____
(Signature)

_____
(Printed Name)

_____
(Telephone Number)

Are you under age 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 Above the Sky Holistic Massage, 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 Above the Sky Holistic Massage from all liability, loss, cost, claim, or damage whatsoever which may be imposed upon Above the Sky Holistic Massage 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)

_____
(Telephone Number)