

MESSAGE THERAPY CLIENT HEALTH INTAKE and POLICY REVIEW



YOUR BODY NEEDS

Thank you for choosing Your Body Needs, LLC as your massage therapy provider! Please fill out the following information so we can tailor your massage session to your specific needs.

Section I:	Client Information	Date _____
Name: _____ I Prefer to be called: _____		
Address: _____ City: _____ State: _____ Zip _____		
Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____		
The best time to contact me is: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. on my <input type="checkbox"/> Home phone <input type="checkbox"/> Work phone <input type="checkbox"/> Cell phone Date of Birth: _____		
Whom may we thank for referring you? _____ Person to contact in case of emergency _____ Phone _____ Email Address _____		
Would you like to receive our e-newsletter? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Section II	Health History
Do you wear contacts? _____ Dentures? _____, Hearing Aid? _____ Pacemaker? _____ List medications you are currently taking or ceased taking less than 6 months ago: _____ Are you currently under medical supervision? _____ If yes, please explain: _____	
Please check any that apply to you and SPECIFY when checked:	
High Blood Pressure <input type="checkbox"/>	
Low Blood Pressure <input type="checkbox"/>	
Epilepsy or seizures <input type="checkbox"/>	
Allergies <input type="checkbox"/>	
Varicose veins <input type="checkbox"/>	
Asthma <input type="checkbox"/>	
A contagious disease <input type="checkbox"/>	
Cancer <input type="checkbox"/>	
Heart problems <input type="checkbox"/>	
Digestive Conditions <input type="checkbox"/>	
Diabetes <input type="checkbox"/>	
Breathing Difficulties <input type="checkbox"/>	
Sensitive Skin <input type="checkbox"/>	
Sinus Problems <input type="checkbox"/>	
Carpel Tunnel <input type="checkbox"/>	
Eating Disorder <input type="checkbox"/>	
Headaches <input type="checkbox"/>	
Pregnant <input type="checkbox"/>	
Muscular problems (tension, cramping, chronic soreness) <input type="checkbox"/> _____	
Vertebral Conditions (herniated, bulging discs, deviations) <input type="checkbox"/> _____	
Recent accident, injury or surgery <input type="checkbox"/> _____	
Emotional difficulties (depression, anxiety, panic attacks, grieving) <input type="checkbox"/> _____	
Joint problems <input type="checkbox"/> _____	
Arthritis (osteoarthritis, rheumatoid) <input type="checkbox"/> _____	



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Circulatory or Blood conditions (arteriosclerosis, varicose veins, phlebitis) _____
Neurological condition (e.g., numbness or tingling in any area of the body, sciatica, damage from stroke, multiple sclerosis)

Immune System conditions (chronic fatigue, HIV/AIDS) _____
Skeletal Conditions (osteoporosis, bone cancer, spinal injury) _____
Previous surgery, disease or other medical condition that may be affecting you now _____
Skin condition (e.g., rash, easy bruising, contagious condition) _____ Nut/
Herb/Essential Oil/ Botanical Allergies _____

Any other medical condition your massage practitioner should know about?

What is your occupation?

Do you sit for long hours at a workstation, computer or driving? If yes, describe (how long, how many days per week, etc.) Do you perform any repetitive movement in your work, sports or hobby? If yes, describe

Do you experience high levels of stress? If yes, do you think stress has affected your health? If yes, indicate how: Muscle tension (), anxiety () insomnia (), irritability (), other ()

Do you experience difficulty lying on your stomach, back or other part of your body?

Is there an area of your body where you are experiencing tension, stiffness, or discomfort?

Do you have any goals in mind for today's session related to any of the conditions mentioned?

I understand that I should see an appropriated health care provider for diagnosis and treatment of any suspected medical problem. I also understand that is my responsibility to keep my massage practitioner informed of any changes in my health and any medications that I may begin to take in the future. The above information will be treated confidentially. By signing this form, I also give consent for future sessions. I have read this form and hereby give permission to be administered therapeutic massage.

Signature _____ Date _____



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Section III:

Your Body Needs Massage Therapy Policies

1. Please be ready to begin each massage session at your scheduled appointment time. If you do arrive late, the session will not be extended. If you fail to show, you will be responsible for payment of the session.
2. Massage sessions range from 50-60 minutes in length unless other arrangements are made.
3. 24 hour notice of cancellation is required should you wish to cancel a massage session. Failure to give required notice will result in a charge for the session.
4. Payment can be made at the office/front desk. We accept all credit cards EXCEPT American Express. In addition, checks, cash and YNB gift certificates are accepted (please see additional gift certificate regulations on the back of the certificate).

Our Guarantee

We are confident that we will provide a valuable service to you. If you feel that you have not gotten value from a therapeutic session, Your Body Needs will gladly refund your massage session fee. The cancellation policies exist because you are purchasing session time with a guarantee that this time is reserved for you.

By signing below, you confirm that you have reviewed and understood these policies.

Date: _____

Client Name: _____

Client Signature: _____

Therapist Signature: _____