



Client Intake and Participation Agreement

Name: _____ D.O.B. _____ Today's Date _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone # _____ Work # _____ Cell # _____

Preferred Contact (*please circle one*): Email Home Phone Work Phone Cell Phone

Emergency Contact: _____ Emergency Contact Phone # _____

How did you hear about B In Touch? _____

Occupation: _____ Have you had Massage Therapy before? Yes / No

Please list any medications and nutritional supplements (prescribed and OTC) you currently take:

Major condition/complaint you'd like to improve:

_____ (Women) Are you Pregnant? Y/N

Past Surgeries: _____ Known allergies: _____

Ever experienced a head or spinal injury? Y/N If yes, please explain: _____

AREAS TO FOCUS: _____

AREAS TO AVOID: _____

How often do you exercise? _____ Do you smoke? Y/N Average hours of sleep per night? _____

Weekly alcohol consumption _____ Weekly caffeine consumption _____

Please check off any of the following conditions that apply to you:

- | | | |
|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Joint Stiffness | <input type="checkbox"/> Swelling _____ | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Broken/Fractured Bones | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Chronic pain |
| <input type="checkbox"/> Strains/Sprains | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Infectious Disease _____ |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Colitis/Crohn's/Diverticulitis |
| | <input type="checkbox"/> Varicose Veins | |

OVER → → → →



Thank you for choosing B In Touch Massage Therapy!

Please review our policies and indicate your agreement by signing below:

Scheduling & Cancelling Appointments

We understand that life can be extremely busy ~ and we're thrilled that you reserve time with us to relax and de-stress! Unfortunately, it is very difficult for us to accommodate late arrivals due to our sessions usually being scheduled back to back. Please try to arrive for your session a few minutes ahead of time, so that you receive the full 30, 60, or 90 minutes on the massage table.

In the event that you need to cancel an appointment, we kindly request that you do so with 24 hours notice. The time slot that we reserve for you is yours alone, and we are often unable to re-book it if a client cancels last minute. If you need to cancel with less than 24-hours notice, please try to send someone in your place. If you cannot attend your time and are unable to find a replacement, you will be charged for the session.

Disclaimer

Massage Therapy is not a substitute for medical treatment and/or medications. Our staff does not diagnose illness or disease, prescribe medication, or perform spinal manipulations. In certain cases of acute illness or injury, a doctor's note may be required for us to proceed with therapy/treatment.

All clients are expected to inform their therapists of all known physical conditions, medical conditions, and medications. Our therapists choose appropriate treatments based on the information disclosed in this form.

In some cases, our therapists will suggest avoiding certain treatments, or the entire session altogether, if he/she feels as though the therapy may be detrimental to the client's condition. We are not responsible for issues that may occur as a result of choosing to continue with treatment.

I, _____, understand all of the above information, and have informed the Massage Therapist of all my known physical conditions, medical conditions, and medications. I will keep my Massage Therapist updated on any changes.

Client Signature _____

Parent/Guardian Signature (if under 18)

Date _____