Bodyworks Massage Center and Gift & Wellness Shop

www.BodyworksMassageCenter.com

Massage & Bodywork Intake Form

CONFIDENTIAL HEALTH HISTORY

Welcome to the place to relax! We are grateful for the opportunity to work with you. Please let us know if you have any questions or concerns regarding your visit.

PLEASE PRINT CLEARLY **TODAY'S DATE: _____**

_____ _____

LAST NAME FIRST NAME MIDDLE INITIAL GENDER *(PRONOUNS OPTIONAL)*

MAILING ADDRESS CITY STATE ZIP

EMAIL ADDRESS *(Required for contact-less checkout, appointment notifications, updates, specials, etc.)*

○ HOME PHONE ○ MOBILE PHONE ○ WORK PHONE

_____ _____ ✓_____

DATE OF BIRTH AGE Parent / Guardian Signature + Printed Name & Relationship (REQUIRED IF UNDER 18)

OCCUPATION EMPLOYER

_____

EMERGENCY CONTACT (Name & Relationship) PHONE

HOW DID YOU HEAR ABOUT US? ○ Existing Client ○ Gift Certificate ○ Medical Referral ○ Social Media
○ Other: _____

IS THIS YOUR FIRST MASSAGE? ○ Yes ○ No HOW LONG SINCE YOUR LAST MASSAGE? _____

WHAT ARE YOUR GOALS OR EXPECTATIONS FOR TODAY'S SESSION? _____

PLEASE NOTE:

- Your late arrival may result in reduced treatment time – with no reduction in price.
- This is a QUIET ZONE. Please speak softly and move gently while you are here.
- Please turn off or mute all electronic devices while in the building.
- Taking photos or videos of other people without their permission is prohibited.
- Please refer to our "Zero Tolerance Policy" *(on display at our front desk)* for information about behavior issues.
- Our massage tables have a working load capacity of 500 lbs. Please let us know if this will be an issue.

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Do you have a HISTORY of any of the following?

○ Abdominal Pain	○ COVID-19	○ Joint Ache	○ Scoliosis
○ Accident	○ Decreased Range of Motion	○ Implants	○ Seizures
○ Anxiety	○ Depression	○ Kidney Disease	○ Shingles
○ Arthritis	○ Diabetes	○ Lupus	○ Shoulder Pain
○ Asthma	○ Eczema	○ Lyme Disease	○ Spinal Stenosis
○ Athletes Foot	○ Edema / Swelling	○ Mastectomy	○ Sprains
○ Back Pain	○ Fibromyalgia	○ MONKEY POX	○ STAPH INFECTION
○ BLOOD CLOTS	○ Gender Reassignment	○ MRSA	○ STROKE
○ Breast Augmentation	○ Gout	○ Neck Pain	○ Surgery
○ Breast Cancer	○ Headaches	○ Osteoporosis	○ Thoracic Outlet Syndrome
○ Broken Bones	○ Heart Attack	○ Palsy	○ Tuberculosis
○ Bursitis	○ Hepatitis	○ PHLEBITIS	○ Varicose Veins
○ Cancer	○ High Blood Pressure	○ Psoriasis	○ Vertigo
○ Carpal Tunnel	○ HIV / AIDS	○ Prosthesis	○ Whiplash
○ Colitis	○ IBS	○ Sciatica	○ DETAILS / OTHER: _____

Do you have any ALLERGIES:
○ None Known ○ Yes: _____

Are you currently taking prescription medication or supplements:
○ No ○ Yes: _____

Are you pregnant?
○ No ○ Yes – Due Date: _____

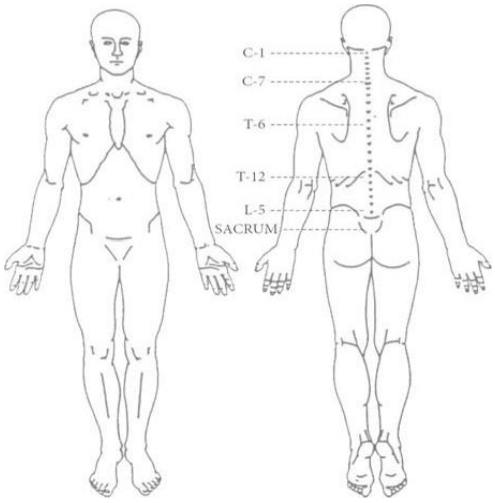
Do any of the following apply to you TODAY?

Also, please let us know at any future appointments if any of the following apply.

○ Cold /Flu	○ Recent Immunization *(24 hrs.)*
○ Fever	○ Severe Pain
○ Incontinent Bladder or Bowel	○ Sunburn
○ Inflammation	○ TAKING PAIN MEDICATION
○ Irritated Skin / Rash	○ Wearing Contact Lenses
○ Medicated Skin Patch	○ Wearing Hearing Aids

○ OTHER: _____

Please indicate with an "X" any areas where you are currently feeling pain or discomfort:



APPOINTMENT CANCELLATION POLICY:

- We require **24-HOURS NOTICE to cancel or reschedule** an appointment. Failure to honor this policy will result in a **LATE CANCELLATION FEE of 50%** of the value of your service -- as well as require a 50% deposit for future appointments.
- Neglecting to call us to cancel an appointment will result in a **NO SHOW FEE of 100%** of the value of your service, payable before any future appointment can be booked – as well as requiring 50% deposit for all future appointments.
- A CREDIT CARD on file is required to HOLD all appointments. A 50% DEPOSIT is required for all appointments booked online. A 50% DEPOSIT may also be required for groups, couples, and other select appointments.

ACKNOWLEDGEMENT:

I confirm that the information provided herein is true and accurate to the best of my knowledge. I understand that massage therapy is not a substitute for medical care and that no diagnosis will be made. I give consent for the use of my confidential health Information for the specific purpose of providing treatment to me and for general administration operations of Bodyworks Massage Center Inc. (BMC). I have read, understand, and agree to abide by the terms of BMC's "Appointment Cancellation Policy" as shown above and understand that payment is due when services are rendered, and in compliance with said policy.

✓_____ _____

Signature Date