

# TAKE TIME

## RELAXATION CENTER<sup>®</sup>

### Client Intake Form (page 1)

*Please fill out all information as accurately and thoroughly as possible*

Name \_\_\_\_\_ Sex \_\_\_\_\_

Address (Street) \_\_\_\_\_

(Town) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email \_\_\_\_\_ Date of Birth \_\_\_\_\_

Occupation \_\_\_\_\_ Referred By \_\_\_\_\_

Emergency Contact (Name and Phone Number) \_\_\_\_\_

Would you be interested in participating in our Slow Down Program? Yes / No

(See Sales Associate for details).

Please circle any conditions you have been diagnosed with or that apply to you

- |                           |                        |                                  |
|---------------------------|------------------------|----------------------------------|
| Current fever             | Cancer                 | Rheumatoid Arthritis             |
| Swollen Glands            | Diabetes               | Fibromyalgia                     |
| Contagious Skin Condition | Epilepsy               | Osteoarthritis                   |
| Open sores or wounds      |                        | Osteoporosis                     |
| Easy bruising             | Surgery                | Tendonitis                       |
|                           | Accident or injury     | Neuropathy                       |
|                           | Fracture               | Joint disorder                   |
| Heart condition           | Sprains / Strains      | Artificial joint                 |
| Circulatory disorder      |                        |                                  |
| Phlebitis                 | Back / neck problems   | Pregnancy How many months? _____ |
| Deep vein thrombosis      | TMJ                    |                                  |
| Varicose Veins            | Headaches / migraines  | Other (please list below)        |
| High / low blood pressure | Carpal Tunnel Syndrome |                                  |
|                           | Tennis elbow           |                                  |

Please explain any conditions that you have marked above and any other conditions not listed above

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Please list any medications you are taking and for what purpose

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Client Intake Form (page 2)

Do you have any allergies ? Yes / No

If Yes, please list below

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Privacy Policy

All information shared on this form will be kept confidential. According to NCBTMB guidelines and CT state licensing policy, we are unable to share information without client's permission.

I, \_\_\_\_\_, (client) have completed this form to the best of my knowledge. I understand that the massage I receive is for the benefit of relaxation and relief of muscular tension. I also understand that the massage therapist cannot diagnose any physical or emotional disorder and that massage therapy is not a substitute for medical treatment. I agree to keep the massage therapist updated as to any changes in my medical profile. It is also my responsibility to communicate about the level of pressure being used, and to alert the therapist about changing the level of pressure upon feeling any discomfort. I understand that if my massage therapist starts the session late, it will be made up to me at the end of the session. I also understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized and I will be charged the full price. I understand that massage therapy sessions are non-sexual. The therapist has the right to end the session, *without refund for either the session or package purchased*, in the case of sexual innuendo or advances from the client, and client has the same right in instance of sexual advances or innuendo from the therapist. I agree to give 24-hour notice for a scheduled session that I cannot keep. I am also aware that I may be charged the full fee for any missed sessions or for sessions that I do not give 24-hours notice to cancel or reschedule. Management determines emergency cancellations.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Under 18 Policy

Please note that clients under the age of 18 MUST be accompanied by a parent or guardian in the room during the session. This policy may be waived if BOTH the parent / guardian and client agree that the adult supervision is not necessary AND only if the client is at least 16 years of age.

I, \_\_\_\_\_ (parent / guardian) have read the above statement and agree to the terms of the policy. I hereby give permission for \_\_\_\_\_ (client) to receive the massage therapy session unsupervised. I have also reviewed the Client Intake Form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Office Use Only

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