inner balance

THERAPEUTIC MASSAGE

Intake Form

Client Information

Name _____ Date _____

Street _____ Day Phone ( ) _____

City _____ State _____ Zip _____ Eve Phone ( ) _____

Occupation _____ Date of Birth _____

Emergency Contact Name and Phone _____ ( ) _____

Referred By _____ Email _____

Massage History / Session Information

Have you ever received a professional massage? ☐Yes ☐No Date of last massage _____

What result do you want from your massage sessions? _____

List any exercise activities. Include frequency: _____

_____

Are you currently under the care of a health care practitioner? ☐Yes ☐No

If yes, specify purpose: _____

List current medications and purpose: _____

_____

Previous History (Include year and treatment received)

Injuries/accidents/illnesses still affecting you: _____

_____

Surgeries: _____

_____

Please mark any of the following that you now have or have had.

Musculoskeletal

- ☐ Bone or joint disease
- ☐ Tendonitis / Bursitis
- ☐ Arthritis / Gout
- ☐ Jaw pain (TMJ)
- ☐ Lupus
- ☐ Spinal Problems
- ☐ Other: _____

Circulatory

- ☐ Heart Condition
- ☐ Phlebitis / Varicose Veins
- ☐ Blood Clots
- ☐ High / Low Blood Pressure
- ☐ Lymphedema
- ☐ Thrombosis / Embolism
- ☐ Other: _____

Please mark any of the following that you now have or have had. (Continued)

Respiratory

- ☐ Breathing difficulty / Asthma
- ☐ Emphysema
- ☐ Allergies specify: _____
- ☐ Sinus Problems
- ☐ Other : _____

Nervous System

- ☐ Shingles
- ☐ Numbness / tingling
- ☐ Pinched Nerve
- ☐ Other : _____

Reproductive

- ☐ Pregnant: Stage
- ☐ Ovarian / menstrual problems
- ☐ Prostate
- ☐ Other : _____

Additional Client Remarks / Comments:

_____

_____

_____

Skin

- ☐ Allergies specify: _____
- ☐ Rashes
- ☐ Athletes foot
- ☐ Herpes / cold sores
- ☐ Other : _____

Digestive

- ☐ Irritable bowel syndrome
- ☐ Ulcers
- ☐ Other : _____

Other

- ☐ Cancer / tumors
- ☐ Bladder / kidney ailment
- ☐ Diabetes
- ☐ Drug / alcohol / caffeine / tobacco use
- ☐ Chronic fatigue
- ☐ Chronic pain
- ☐ Sleep disorders
- ☐ Migraines / headaches
- ☐ Anxiety / Depression
- ☐ ADD / ADHD
- ☐ Contact lenses (hard or soft)

Please indicate your area/s and type/s of pain on the figure below:

Numbness ---------- **Pins & Needles** oooooooooo **Burning** xxxxxxx **Aching** ******** **Stabbing** ////////////////

Notes: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please place a mark at the level of your pain on the scale below

No Pain ├──────────────────────────────┤ **Worst Possible Pain**

inner balance

THERAPEUTIC MASSAGE

Release Form:
I understand that the massage/energy therapy that I receive is provided for the basic purpose of relaxation, stress reduction, relief of muscular tension and is non-sexual. Any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment. If I experience any pain or discomfort during this session, I will immediately inform he practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/energy therapy should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware.

Because massage/energy therapy is contraindicated under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered questions honestly. I agree to keep Inner Balance therapists updated as to any changes in my medical profile and understand that there shall be no liability on the part of Inner Balance therapists should I fail to do so. Should I need to cancel future sessions, I agree to give my practitioner 24 hours notice or I will be financially responsible for the session time.

I further acknowledge that I am voluntarily participating in the above referenced activities with the full knowledge and understanding that said activities are taking place during the COVID-19 pandemic. I understand that while Inner Balance, LLC therapists will abide by all local, state, and federal government laws and guidelines, as well as CDC guidelines, in an attempt to keep therapist and guests safe, that I assume ALL risks associated with participation in said activities during said pandemic, including but not limited to: any illness and any adverse physical and/or psychological effects from the same and/or loss of any income or other monetary loss incurred as a result of the effects of said illness and/or costs incurred in the treatment of the same. I accept full and total responsibility for my own health and agree to release, hold harmless, and indemnify, to the extent permitted by the law, Inner Balance, LLC therapists from any liability for any illness, injury, loss or damages I many incur as a result of contracting COVID-19 as a result of engaging in said above referenced activities.

I have read, understand, and agree to the content of this Agreement and voluntarily agree to the terms and conditions stated above.

Client Signature: _____ Date: _____

Practitioner: Penny Pecaut-Ziglin Date: _____

Parent/Legal Guardian of Minor Under Age 18: _____ Date: _____