inner balance

THERAPEUTIC MASSAGE

First Name _____

Last Name _____

Email Address _____

Home Phone # _____

Street Address _____

State _____

Emergency contact name _____

Emergency contact relationship _____

Emergency phone # _____

Date of initial visit _____

Date of birth _____

Referred by _____

Mobile Phone # _____

City _____

Zip Code _____

Physician's name _____

Physician's phone # _____

How would you rate your general health?

- ◯ Excellent
- ◯ Good
- ◯ Fair
- ◯ Poor

Have you had a professional massage before?

- ◯ Yes (Date of last treatment) _____
- ◯ No

List current medications & the conditions they are treating

_____

_____

_____

_____

_____

List any major accidents or surgeries (including dates)

_____

_____

_____

_____

_____

Please tell us about any allergies or hypersensitivities

_____

_____

_____

_____

Reason for initial visit

_____

_____

_____

_____

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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: _____