



Date: \_\_\_\_\_

# Client Health Intake Form

Personal Information						
Last Name		First Name				
Address						
Primary Phone		E-mail Address				
Emergency Contact		Phone	D.O.B. / /			
Health Information						
Height	Weight					
Have you had massage before? Y / N    What goal(s) do you have in coming for massage therapy?						
Do you take any medicines or supplements? YES / NO    If yes, which ones?						
<b>Circle any conditions that you have now or have had in the past.</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"> Allergies / Sinus  Arthritis / Joints Problems  Asthma  Cancer  Depression  Diabetes/Sugar  Edema/Swelling </td> <td style="width: 33%;"> Epilepsy  Fibromyalgia  Fractures  Heart Condition  Hernia  Hemophilia  HIV/AIDS  IBS/Digestive </td> <td style="width: 33%;"> Low/High Blood Press.  Menopause  Open Wounds  Osteoporosis  Pregnant  Skin Condition  Spinal Condition  Stroke </td> </tr> </table>			Allergies / Sinus Arthritis / Joints Problems Asthma Cancer Depression Diabetes/Sugar Edema/Swelling	Epilepsy Fibromyalgia Fractures Heart Condition Hernia Hemophilia HIV/AIDS IBS/Digestive	Low/High Blood Press. Menopause Open Wounds Osteoporosis Pregnant Skin Condition Spinal Condition Stroke	<b>Circle any areas of pain and X any areas of severe stress or tension.</b>
Allergies / Sinus Arthritis / Joints Problems Asthma Cancer Depression Diabetes/Sugar Edema/Swelling	Epilepsy Fibromyalgia Fractures Heart Condition Hernia Hemophilia HIV/AIDS IBS/Digestive	Low/High Blood Press. Menopause Open Wounds Osteoporosis Pregnant Skin Condition Spinal Condition Stroke				
<b>Other:</b> _____ _____						

## Agreement

Massage is not a substitute for medical attention, examination, diagnosis, or treatment. I have listed all current and past health and medical concerns to the best of my knowledge. As is the case with any physical activity, the risk of injury is always present and cannot be entirely eliminated. If I experience any pain or discomfort, I will ask for support or adaptation from the therapist. I affirm that I alone am responsible to decide whether to receive massage.

*By providing your e-mail and postal address, you are authorizing permission for Revolve Massage Therapy to send you updates regarding services or offerings. If you do not want to receive these updates, you may initial here \_\_\_\_\_.*

## Right of Refusal

I understand that Revolve Massage Therapy reserves the right to refuse service to anyone for any reason, including individuals that abuse or misuse services in any manner, i.e., seeking sexual massages, non-compliance with treatment, frequent missed appointments, etc. We also reserve the right to refer future services of individuals whose concerns are beyond our service capacity. Likewise, I understand that I, the Client, have the right to refuse services for any reason at any time and that my needs will be respected at all times.

## Cancellation Policy

I am aware that there is a 24-hour cancellation policy. If I do not call to cancel within 24 hours of my scheduled appointment time, I will be billed for the session and must pay before additional services are rendered. Additionally, I am aware that any session interrupted before completion will still be billed.

Client Signature &amp; Date

Therapist Signature &amp; Date