RENEW BY JENNIFER, LLC INTAKE FORM

Client Information

Name: _____ Date of Birth: _____

Address:_____
Street City State Zip

Phone: (Day)_____ (Evening)_____ Email _____

Preferred contact for appointment reminder: ___ Telephone ____ Text ___ Email

Occupation/Employer? _____

How did you hear about us?: _____

Emergency Contact: (Name, Relationship, and Phone Number)

_____

Client History

Have you ever received a professional massage? _____ If yes, how often?_____

Do you have any allergies to oils, lotions, ointments or perfumes? _____

Do you have any difficulty lying on your front, back, or side? _____

Is there a particular area of the body where you are experiencing tension, pain or other discomfort? _____
If yes, please identify where: _____

Do you have sensitive skin? ____ Are you wearing contact lenses? ____ dentures? ____ hearing aid? _____

Do you sit or stand for long hours at a workstation, computer, or driving? _____

What are your activities, hobbies, and exercise? _____

Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

Are you currently under medical supervision? _____ Doctor's name: _____

Have you ever had chiropractic adjustments? _____ If so, how often? _____

Injuries, accidents, or illnesses still affecting you: _____

_____

Past surgeries (include date):_____

_____

Please list all current medications and reasons: _____

_____

Health History

Please mark any of the following that you now have with a C (Current) or have had with a P (Past):

Skin
___Rashes
___Athlete's foot
___Cold Sores/Herpes
___Bruise easily
___Open wounds/cuts/sores

Musculoskeletal
___Bone or joint disease
___Tendonitis/Bursitis
___Arthritis/Gout
___Artificial Joint/Plates/Screws
___Broken Bones/Sprain/Strain
___Whiplash
___Jaw pain (TMJ)
___Spinal problems
___Scoliosis
___Osteoporosis
___Lupus

Psychological
___Anxiety/Stress
___Depression

Circulatory
___High/Low Blood pressure
___Heart Condition
___Varicose veins/Phlebitis
___Lymphedema
___Thrombosis/Blood Clots

Respiratory
___Asthma/Breathing Difficulty
___Emphysema
___Sinus problems
___Allergies

Digestive
___Irritable bowel syndrome
___Ulcers
___Bladder/kidney ailment
___Colitis
___Crohn's disease
___Constipation
___Acid reflux

Nervous System
___Headaches/Migraines
___Seizures
___Numbness/tingling
___Pinched nerve
___Fibromyalgia/Chronic fatigue
___Paralysis
___Shingles
___Multiple Sclerosis
___Parkinson's Disease

Reproductive
___Pregnant? Due date: _____
___Ovarian/Menstrual problems
___Prostate

Other
___Cancer/tumors
___Diabetes
___Chronic pain
___Sleep disorder

Any other medical conditions not listed: _____

Is there anything else about you or your health history that you think would be useful for me to know before?

_____

_____

Client Consent for Treatment/Cancellation Policy

If I experience any pain or discomfort during this session, I will immediately inform the therapist so the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I understand that certain conditions or medications may contraindicate (not permit) massage or may require the use of alternate techniques or pressure. The massage therapist reserves the right to refuse to perform massage on anyone whom she deems to have a condition for which massage is contraindicated. I understand that massage may be advisable by my physician, but not by my massage therapist. In that event, I agree to provide a written agreement from my physician before proceeding with treatment.

I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I agree to abide by a 24 hours cancellation notice for any scheduled massage. I understand I may be charged up to the full amount of service for missed appointments or for any cancellations with less than a 24 hour notice. I understand that if I arrive late for an appointment, the session will end at the original scheduled time to prevent penalizing another client.

Client Signature:_____ **Date**:_____

Massage Therapist Signature:_____ **Date**:_____