

Massage Intake Form

Name: _____ DOB: _____ F / M

Address: _____

Phone: _____ Occupation: _____

E-mail address (for surveys / newsletters): _____

Emergency contact / name: _____ / _____

Health Fund (if you want to claim): _____

How did you learn of ToThePoint Massage? _____

Please list any recent or past accidents and surgeries and current medical conditions:

Are you currently taking any medication / supplements? _____

Are you currently under medical treatment? Yes / No If so what condition: _____

Are you allergic to sunflower or apricot oil? Yes / No

Health issues (even minor ones) – please tick if applicable:

- | | | |
|--|--|--|
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Brittle Bones | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Neuropathy / Numbness | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Venous Disease | <input type="checkbox"/> Edema / Lymphedema | <input type="checkbox"/> Jaw problems |
| <input type="checkbox"/> Blood Clotting Disorder | <input type="checkbox"/> Heat Sensitivity | <input type="checkbox"/> Disc / spinal problems |
| <input type="checkbox"/> Skin infection / problems | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Joint dysfunction |
| <input type="checkbox"/> Cancer / tumour | <input type="checkbox"/> Hearing difficulties | <input type="checkbox"/> Different long legs |
| <input type="checkbox"/> Flu / Cold | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Other |

Further details / notes:

Please fill out the 2. + 3. page, too

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

Did you have a covid vaccine? Yes / No If yes, when? _____
(Please cancel your appointment again if you had the Covid19 or any other vaccine in the last 4 days.)

What kind of sports do you do? _____

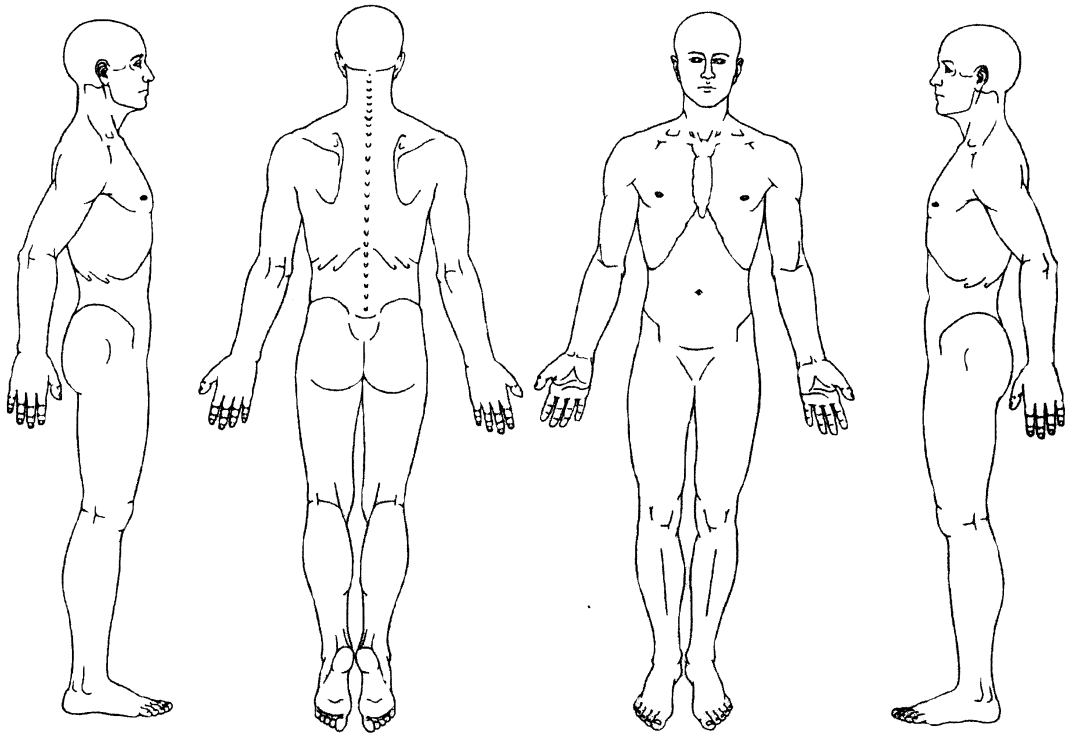
What would you like to achieve from your massage session? Please note that health funds do NOT pay for stress relief.

Pain reduction Muscular Relaxation Stress Relief Other _____

What relieves your pain or discomfort? (Leave blank if this doesn't apply to you)

What causes your pain or makes it worse? (Leave blank if this doesn't apply to you)

Please mark your areas of pain / stiffness:



Cancellation Policy

We kindly ask that you provide us with a **24 hour notice** of any schedule changes or cancellation requests. Any cancellation or reschedule less than 6 hours prior to treatment will result in a cancellation fee of \$30 unless reasonable cause. If you do not show up, and did not notify us to cancel, you will be charged the full fee of your missed appointment.

Please understand that when you cancel or miss your appointment without providing a 24 hour notice we may be unable to fill that appointment. This is an inconvenience to a small business and also means that other clients miss the chance to receive services they need.

Treatment Agreement

I understand that massage may provide benefits for certain conditions but results are not guaranteed. These benefits may include relief from muscular tension, spasm, stiffness, or pain and stress reduction. If I experience any pain or discomfort during this session, I will immediately tell Barbara so that the pressure and/or strokes may be adjusted to my level of comfort.

I understand that massage therapists are not qualified to diagnose any illness or disease, and nothing said or done during the session should be construed as such.

I further acknowledge that massage 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 that I am aware of.

Because massage 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 do not expect Barbara to have foreseen any previous or pre-existing condition that I have not mentioned.

It is common to have some muscle soreness, mild bruising, increased awareness of areas of pain and light-headedness amongst other possible temporary outcomes **for one or two days** after receiving deep corrective massage.

Barbara understands that I have the right to question procedures used and to receive an explanation of any procedures that she performs.

Understanding all this, I give my consent to receive care by Barbara and agree to the cancellation policy.

Signature

Date