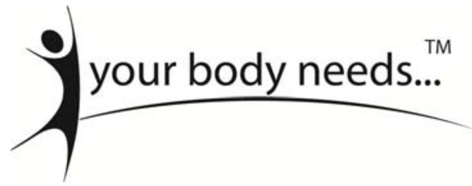


MASSAGE THERAPY CLIENT HEALTH INTAKE and POLICY REVIEW

Thank you for choosing Your Body Needs, LLC as your massage therapy provider! Please fill out the following information so we can tailor your massage session to your specific needs.

Section I: Client Information Date______________

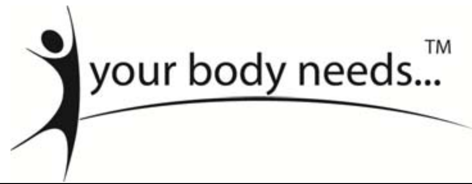
Name:____ I Prefer to be called: _________________________
Address:____City:______________State:_________Zip_______________
Phone (______)_________________ Work Phone (_____) ________________ Cell Phone (______)___________________
The best time to contact me is:_________________ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Date of Birth:_______________
Whom may we thank for referring you? ____
Person to contact in case of emergency____________________________________ Phone_________________________
Email Address____ Would you like to receive our e-newsletter? ☐ Yes ☐ No

Section II Health History

Do you wear contacts? ______ Dentures?______, Hearing Aid? ______Pacemaker?_______
List medications you are currently taking or ceased taking less than 6 months ago:
____
Are you currently under medical supervision? ____ If yes, please explain:
____

Please check any that apply to you and SPECIFY when checked:

High Blood Pressure □
Low Blood Pressure □
Epilepsy or seizures □
Allergies □
Varicose veins □
Asthma □
A contagious disease □
Cancer □
Heart problems □
Digestive Conditions □
Diabetes □
Breathing Difficulties □
Sensitive Skin □
Sinus Problems □
Carpel Tunnel □
Eating Disorder □
Headaches □
Pregnant □
Muscular problems (tension, cramping, chronic soreness) □___________________________________
Vertebral Conditions (herniated, bulging discs, deviations) □ __________________________________
Recent accident, injury or surgery □ ____
Emotional difficulties (depression, anxiety, panic attacks, grieving) □ ____________________________
Joint problems □ ____
Arthritis (osteoarthritis, rheumatoid) □ ____



Circulatory or Blood conditions (arteriosclerosis, varicose veins, phlebitis) □ ____________________________
Neurological condition (e.g., numbness or tingling in any area of the body, sciatica, damage from stroke, multiple sclerosis) □ ____
Immune System conditions (chronic fatigue, HIV/AIDS) □ ____
Skeletal Conditions (osteoporosis, bone cancer, spinal injury) □ ______________________________________
Previous surgery, disease or other medical condition that may be affecting you now □ ____________________
Skin condition (e.g., rash, easy bruising, contagious condition) □ _____________________________________
Nut/ Herb/Essential Oil/ Botanical Allergies □ ____

Any other medical condition your massage practitioner should know about?

What is your occupation?
Do you sit for long hours at a workstation, computer or driving? If yes, describe (how long, how many days per week, etc.)
Do you perform any repetitive movement in your work, sports or hobby? If yes, describe

Do you experience high levels of stress? If yes, do you think stress has affected your health? If yes, indicate how: Muscle tension ( ), anxiety ( ) insomnia ( ), irritability ( ), other ( )

Do you experience difficulty lying on your stomach, back or other part of your body?

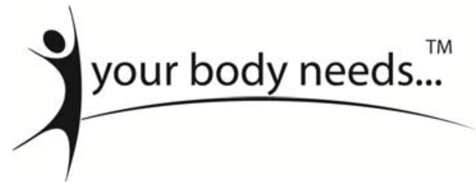
Is there an area of your body where you are experiencing tension, stiffness, or discomfort?

Do you have any goals in mind for today's session related to any of the conditions mentioned?

I understand that I should see an appropriated health care provider for diagnosis and treatment of any suspected medical problem. I also understand that is my responsibility to keep my massage practitioner informed of any changes in my health and any medications that I may begin to take in the future. The above information will be treated confidentially. By signing this form, I also give consent for future sessions. I have read this form and hereby give permission to be administered therapeutic massage.

Signature____ Date______________________________

Your Body Needs, LLC 1684 Village Green, Suite 2 Crofton, MD 21114
(443)292-4395 | www.yourbodyneeds.com



Section III: Your Body Needs Massage Therapy Policies

1. Please be ready to begin each massage session at your scheduled appointment time. If you do arrive late, the session will not be extended. If you fail to show, you will be responsible for payment of the session.

2. Massage sessions range from 50-60 minutes in length unless other arrangements are made.

3. 24 hour notice of cancellation is required should you wish to cancel a massage session. Failure to give required notice will result in a charge for the session.

4. Payment can be made at the office/front desk. We accept all credit cards EXCEPT American Express. In addition, checks, cash and YNB gift certificates are accepted (please see additional gift certificate regulations on the back of the certificate.

Our Guarantee
We are confident that we will provide a valuable service to you. If you feel that you have not gotten value from a therapeutic session, Your Body Needs will gladly refund your massage session fee. The cancellation policies exist because you are purchasing session time with a guarantee that this time is reserved for you.

By signing below, you confirm that you have reviewed and understood these policies.

Date: _________________
Client Name: _______________________
Client Signature:_________________________
Therapist Signature: __________________________