

Client Intake Form

The information collected in this form will be used only for the purpose of designing an appropriate massage therapy program for you and will not be disclosed to any third party without your consent.

Date _____ D.O.B. _____ Age _____ Marital Status _____

Name _____ email: _____

Address _____ City, ST Zip _____

Phone _____ Mobile _____ Work _____

Occupation _____ Employer _____

In case of emergency, please notify: Name _____ Phone _____

Current or Previous major illnesses _____

Current or Previous injuries or accidents _____

Please check if any of the following are relevant to your medical history:

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Flu/Cold | <input type="checkbox"/> Scoliosis/Lordosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Skin Disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Previous MVA/trauma | <input type="checkbox"/> Any infectious conditions _____ |
| <input type="checkbox"/> Other _____ | | |

Females Only - please mark if you are or are trying to get pregnant _____ weeks

Are you currently under the care of a physician? No Yes if yes, _____

Are you currently taking any medications? No Yes if yes, please list _____

We reserve the right to request a doctor's clearance before allowing you to receive massage therapy services.

Purpose/Reason for today's visit _____

Do you exercise regularly? No Yes

Are you allergic to any nuts or oils? No Yes _____

Type _____ Frequency _____

For injuries/pain:

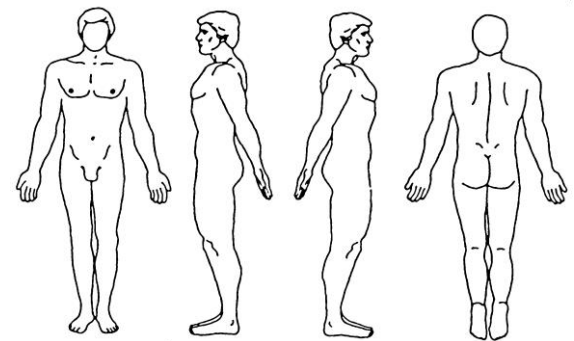
Areas of any discomfort/pain _____

How long have you had this pain/injury? _____

Have you sought out other therapies/treatments? No Yes

if yes, list _____

* what do you think is causing injury/pain? _____



Indicate pain/discomfort with an 'X'

How did you hear about us? Please circle one.

- Drive By _____
- Internet _____
- Body Logic Staff _____
- Event Which one? _____
- Friend/Family Name? _____

- Sandbridge Vacation Guide _____
- Oceana Base Guide _____
- Standard Process or BioFreeze Website _____
- St. John's Bulletin _____

Massage Therapy Acknowledgement:

- ◆ Focused attention and manual therapy will be given as agreed upon by the massage therapist and client for the predetermined goals of stress reduction, relief of muscular discomfort, and or health promotion. I understand that the massage therapist is not a licensed physician or chiropractor.
- ◆ I will immediately inform my massage therapist of any unusual sensation or discomfort, so that the application of pressure of strokes/technique(s) may be adjusted to my level of comfort, and agree to disclose any physical limitations, disabilities, ailments, or impairments which may affect my ability to receive soft tissue therapy and massage services.
- ◆ I understand that there is no implied or stated guarantee of success or effectiveness with massage therapy treatments.
- ◆ I understand that by signing this form, I give my consent to receive the massage therapy treatments discussed in the initial and all future sessions and agree that my presence at subsequent sessions shall be construed to be continuation of this written consent. Also, by signing this form, I hereby release Body Logic, PC and any therapist providing services through Body Logic, PC from any and all liability relating to soft tissue therapy and massage services received.
- ◆ I have read and agree to Body Logic's fee schedule.

Liability Waiver and Release:

By signing below, the client acknowledges that they are aware of their own health and physical condition. Having such knowledge, the client further acknowledges that they are voluntarily receiving soft tissue therapy and massage services from Body Logic, PC and hereby assumes all risks connected therewith and consent to receive such therapy and services. The client also hereby releases and holds harmless Body Logic, PC, its massage therapists, officers, and employees of any liability, loss, cost, damage, expense, claim, or suit whatsoever for any or all injury, loss, illness, harm, cost, expense, claim, suit, damage or other claim resulting from, related to, or in any way arising from my receipt of soft tissue therapy and massage services.

IN NO EVENT WILL BODY LOGIC, PC BE LIABLE FOR CONSEQUENTIAL OR INCIDENTAL DAMAGES INCLUDING, WITHOUT LIMITATION, ANY CLAIM OR DEMAND AGAINST THE CLIENT BY ANY OTHER PARTY DUE TO ANY CAUSE WHATSOEVER, EVEN IF THE CLIENT HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. BODY LOGIC, PC'S LIABILITY HEREUNDER, REGARDLESS OF THE FORM OF ACTION, SHALL NOT EXCEED THE TOTAL AMOUNT PAID FOR SERVICES UNDER THIS AGREEMENT, WHICH SHALL BE THE CLIENT'S SOLE AND EXCLUSIVE REMEDY.

The client understands that the owner of and agent for any property where soft tissue therapy and massage services are provided will be third party beneficiaries of this Liability Waiver and Release.

This Liability Waiver and Release shall be effective as of the client's signature below, shall remain in effect for all future sessions with Body Logic, PC, and shall survive termination of client's receipt of services from Body Logic, PC.

Client Signature: _____

Date: _____