CLIENT INTAKE FORM

Date: _____

Title: _____ **Preferred Pronouns:** _____

Last Name: _____

First Name: _____ **Middle Initial:** _____

Suffix: _____ **Birth Date**_____/_____/_____ **Birth Chromosomes:** XX XY

Home Address:_____

Apartment/Suite: _____

City: _____**State:** _____ **Zip Code:** _____

Preferred Phone Number: _____ **Secondary Phone Number:** _____

Email Address: _____

- ***Emergency Contact:***

Name: _____

Relationship: _____ **Phone Number:** _____

- ***Occupation:***

Title: _____

Please circle which most applies to the physical demands of your occupation:

Sedentary *(office administration, telecommunications, computer engineering, web design, food delivery)*

Low-Activity *(barbers/hairdressers/stylists, teachers/instructors, chemists, hotel/motel/resort desk clerks)*

Moderate Activity *(food service/waiting tables, custodial, warehouse, package delivery, roofers, lab work)*

High Activity *(HVAC, heavy equipment operators/mechanics, occupational therapy, linemen, contractors)*

Intense Activity *(construction, healthcare professionals, professional athletes, community & social services)*

- ***Primary Care Physician:***

Name: _____ ***Phone Number:*** _____

Street Address:

_____

Apartment/Suite: _____

City: _____ **State:** _____ **Zip Code:** _____

Email Address:

_____

CLIENT INTAKE FORM

Health History:

Please advise which conditions apply to you by filling in the corresponding bubble:

Cardiovascular

- O Congestive heart failure
- O Embolism
- O Heart attack
- O Heart disease
- O Hemophilia
- O High blood pressure
- O Low blood pressure
- O Pacemaker
- O Phlebitis
- O Poor circulation
- O Stroke
- O Thrombosis
- O Varicose veins
- O Family history

Head & Neck

- O Dizziness
- O Ear problems
- O Headaches
- O Hearing loss
- O Jaw pain (TMJ)
- O Migraines
- O Vision loss
- O Vision problems

Musculoskeletal

- O Arthritis
- O Artificial joint
- O Bursitis
- O Osteoporosis
- O Surgical pin/wire
- O Tendonitis

Neurological

- O Epilepsy
- O Multiple sclerosis
- O Numbness/tingling
- O Sensory loss/change
- O Sciatica
- O Seizures

Respiratory

- O Asthma
- O Bronchitis
- O Chronic cough
- O Emphysema
- O Shortness of breath
- O Sinusitis
- O Smoker
- O Tuberculosis
- O Family history

Reproductive

- O Given birth
- O Gynecological problems
- O Pregnant

Skin

- O Bruise easily
- O Skin conditions
- O Skin infections
- O Skin irritations

Miscellaneous

- O Anxiety
- O Cancer
- O Depression
- O Diabetes
- O Digestive conditions
- O Fibromyalgia
- O HIV/AIDS
- O Stress
- O Other

O Vertigo

CLIENT INTAKE FORM

- ***Please rate your general health by circling the most appropriate image on the scale below:***

Awful ***Alright*** ***Average*** ***Great*** ***Immaculate***

- ***Please describe any problem areas that you would like addressed during your treatment, and whether they are long-term or recent concerns, and whether you have already received treatment (if so, what treatment(s), when, and what were the results?):***

- ***Please describe any recent injuries, and whether you have already received treatment for them (if so, what treatment(s), when, and what were the results?):***

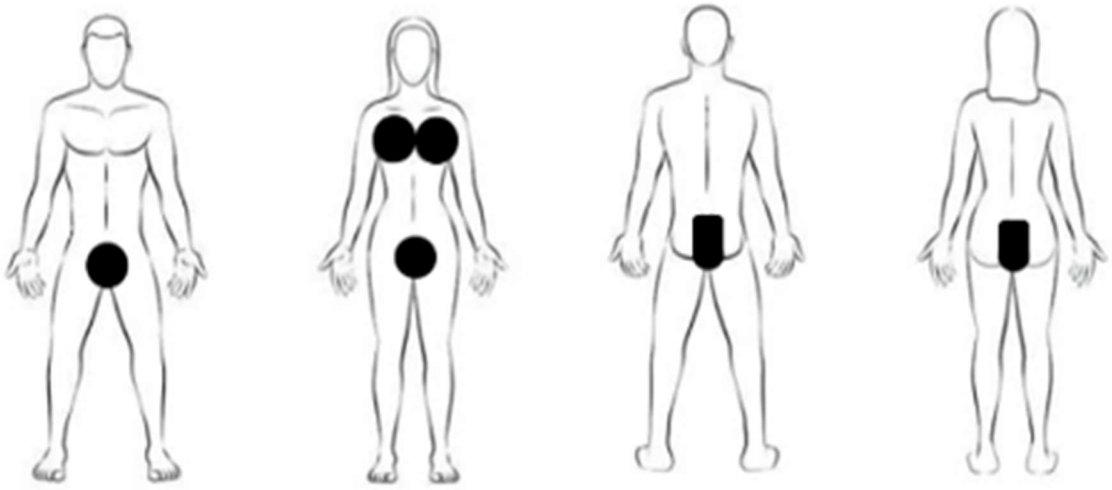
- ***Please list any allergies to scents, oils, lotions, and/or detergents:***

- ***Please list all over the counter, prescription medications, and recreational drugs that you are currently using:***

CLIENT INTAKE FORM

- ***Are you currently pregnant, and if so, what trimester, what symptoms and complications are you experiencing, and has your primary care provider approved massage therapy?***

- ***Please circle any of the areas of the body that you would not like touched (note that the genitals, breasts, and gluteal cleft region will never be touched unless there is a direct purpose as requested in writing by the client or a referring medical provider, and the procedure will be explicitly discussed and agreed to prior to the treatment):***



- ***Trauma Informed Container Commitment***

Moonwing Massage, PLLC commits to providing a trauma informed container. This means that we consider our space, our staff, and our therapists as trauma informed, such as but not limited to: Providing a safe space for those with physical and psychological disease, illness, and trauma. We commit to operating in consideration of each client's unique needs to provide the necessary and appropriate safe space, as required in real-time. Prior to each appointment, please update your therapist or the business of any changes to your needs, as it relates to providing you the most appropriate access to care and comfort for treatment.

- ***Referred By:***

Name: _____

Relationship: _____ ***Are they an existing Moonwing Client?:*** *Yes No Not Sure*

CLIENT INTAKE FORM

- ***Pricing & Payment Policy – Please read and initial the statements below to acknowledge understanding of the policy.***

_____ *I understand that prices and services are subject to change based on business, industry, and inflation needs at any time.*

_____ *I understand that additional services may be offered based on my condition or interest, and that they may be an extra cost, which will be discussed with me and approved by me prior to rendering the services.*

_____ *I understand that Moonwing Massage, PLLC honors a gift-credit program and that that these funds are honored as a purchase-value care investment. These gift credits are not redeemable or refundable for cash, and do not expire. I understand that when gifting, the credit recipient will be responsible for scheduling and utilizing the credits. I understand that these gift credits can be gifted from my account to others as I see fit, and that this is done with Moonwing directly.*

- ***Cancellation, Rescheduling, and Late Fees Policy – Please read and initial the statements below to acknowledge understanding of the policy.***

_____ *I understand that cancellations and reschedules must occur 48 hours prior to my scheduled appointment, or my account will be charged 100% of the originally planned service, which must be paid prior to further service being approved.*

_____ *I understand that after my initial consultation and treatment, the first 14-minutes of my session will be used for consult and disrobing, with some reserved for re-dressing after my session. I understand that my appointment end-time will remain the same regardless of my tardiness, so when I am up to 14-minutes late, I will lose that time and still be charged for the full appointment.*

_____ *I understand that, as a courtesy to my therapist and the clients scheduled after me, if I am 15 or more minutes late, I will be considered a no-show, and that my appointment will be canceled but I will still be charged the full cost of the initially planned services.*

_____ *I understand that there is a 3-strike policy for no-shows or reschedules/cancellations within the 48-hour cancellation window. Upon exhausting all 3 strikes, I will no longer be scheduled for future visits.*

_____ *I understand that unpaid invoices are tracked closely, and those greater than 30-days past service-date are sent timely through proper collection channels and authorities, to the extent of the law.*

- ***Privacy Policy – Please read and initial the statements below to acknowledge understanding of the policy.***

_____ *I understand that my therapist and the staff at Moonwing Massage, PLLC , will abide by HIPAA (Health Insurance Portability & Accountability Act) law to properly maintain, protect, and keep private my sensitive personal information, including but not limited to my health history and documentation, contact information, and personally identifiable information. I know that my information will be shared only in extenuating and legally approved circumstances, such as but not limited to occasions where my information may be requested and shared with other healthcare providers upon receipt of the appropriate release documents and/or by mandatory compliance with court subpoena.*

CLIENT INTAKE FORM

- ***Liability Waivers – Please read and initial all statements below to become a Client of Moonwing Massage, PLLC:***

_____ *I understand that this client intake form will expire every 2 years and require re-completion before my first appointment after each 2-year expiration date, in efforts to ensure my contact and health history information is up to date.*

_____ *I understand that massage therapy is intended to reduce stress, provide relaxation, ease muscular tension, and to improve circulation, lymphatic function, and energy flow.*

_____ *I understand that body and energy work are not a substitute for necessary medical care and that my therapist is not qualified to diagnose, prescribe, or treat physical illness &/or mental wellness.*

_____ *I know that I have the right to halt a therapy session at any time that I become uncomfortable, by simply asking my therapist to change their pressure, move to a different part of my body, or completely stop the massage. I will not hold my therapist responsible for discomfort I feel during or after a massage.*

_____ *I affirm that I have thoroughly described my medical conditions and medications, recent injuries, and areas on my body that I would like avoided, within this intake form.*

_____ *I agree to keep my therapist informed of any health, medication, and injury changes prior to each appointment. I will not hold my therapist responsible for adverse effects of treatment in the event that I did not properly update them prior to treatment.*

_____ *I confirm that I have received a copy of the therapist's cancellation and fee policies, and I understand that these policies as well as treatment prices are open to change as business needs demand.*

_____ *I have received, read, and understand the Trauma Informed Container Commitment.*

_____ *I understand that I have the right to copies of my client files at any time, upon written request, and that my Primary Care Physician may also request copies of my client files. I understand that there may be a fee for printing these files or for recording them to a disc or zip drive.*

_____ *I give right to my therapist and the office staff to contact my Primary Care Physician regarding questions and concerns about my health, as it relates to partnering with them to ensure I am getting the proper massage, bodywork, or energy work to accommodate current conditions, injuries, or mental wellness.*

_____ *I understand that massage therapy is just that – therapy – and not sexual in nature. I agree not to sexually harass my massage therapist or their staff, and that verbal abuse and sexual harassment of the staff and therapist is not tolerated and will result in law-enforcement involvement and refusal to service further.*

_____ *By signing this document, I have released my therapist and their staff from any liability – whether it be past, present, or future – related to treatment they provide or refuse to provide, including but not limited to: massage therapy, bodywork, and energy work.*

- ***Please finalize this document by completing the signature spaces below and returning the form to MoonwingMassage@Outlook.com no less than 2 business days prior to your appointment, or bring to your appointment at least 15 minutes prior to your scheduled start-time. If the client is under 18 years of age, please complete the Minor Liability Release Form below.***

Signature: _____ ***Date:*** _____

Printed Name: _____ ***Initials:*** _____

CLIENT INTAKE FORM

Complete only if the client is under the age of 18 at the time of initial consultation or treatment:

- ***MINOR LIABILITY RELEASE***

By signing below, you are certifying that you are the parent or legal guardian of the minor receiving massage therapy treatment(s). You also understand that you will be required to remain at the facility and in the treatment room for the entirety of the minor's treatment(s), to supervise all interactions between the therapist and minor. You also agree that you have informed the massage therapist about all relevant medical history, symptoms, medications, and/or concerns associated with this minor.

PLEASE PRINT CLEARLY:

I _____, certify that I am the parent or legal guardian of _____, who is ____ years of age. I understand the scope of massage therapy and that it is not meant to diagnose, treat, or cure any conditions and is not a replacement for standard medical care. I give permission for my minor child to receive treatment(s) at this facility and agree to all the above terms.

Signature: _____ ***Date:*** _____

Printed Name: _____ ***Initials:*** _____

OFFICE USE ONLY

Therapist to Review & Complete Prior to Initial Consultation/Treatment:

Reviewed By: _____ ***Expiration Date:*** _____

Consultation/Treatment Approved: ***Yes*** ***No*** ***Reschedule***

Contraindications Noted: _____

Recommended Wait for Treatment: _____

Referral to Other Professional: _____