Brilliant Bodywork

Massage Therapy Intake

Name_____ Phone (Home)_____Phone (Mobile)_____

Address_____ City_____ Zip_____

Email_____ Date of Birth_____ Occupation_____

Emergency Contact_____ Phone_____

How did you learn about Brilliant Bodywork? _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

1. Have you had a professional massage before? If so, when?_____
2. Do you have difficulty lying on your front, back or side? _____
3. Do you have ANY known allergies/sensitivities?_____
4. Do you have sensitive skin?_____
5. Are you wearing contact lenses, dentures or a hearing aid? (Circle those that apply.)
6. Do you sit for long hours at a workstation, computer or driving?_____
7. Do you perform any repetitive movement in your work, sports or hobby?_____
8. Do you experience stress in your work, family or other aspect of your life?_____
9. Muscle Tension, Anxiety, Insomnia, Irritability or other:_____
10. Is there a particular area where you are experiencing tension, stiffness, pain or other discomfort (diagram on back)? _____
11. Are you currently under medical supervision?_____
12. Do you see a chiropractor? If so how often?_____
13. Are you currently taking any medication?_____
14. Please circle any conditions that apply to you: contagious skin conditions, open sores or wounds, easy bruising, recent accident or injury, recent fracture, recent surgery, artificial joint, sprains/strains, current fever, swollen glands, allergies/sensitivities, heart condition, high or low blood pressure, circulatory disorder, varicose veins, atherosclerosis, phlebitis, deep vein thrombosis/blood clots, joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis, osteoporosis, epilepsy, headaches/tension/migraines, cancer, diabetes, decreased sensation, back/neck problems, fibromyalgia, TMJ, carpal tunnel syndrome, tennis elbow, pregnancy, accutane, retin a, or pacemaker.
15. Is there anything else about your health history that you think would be useful for your massage practitioner to know about?_____

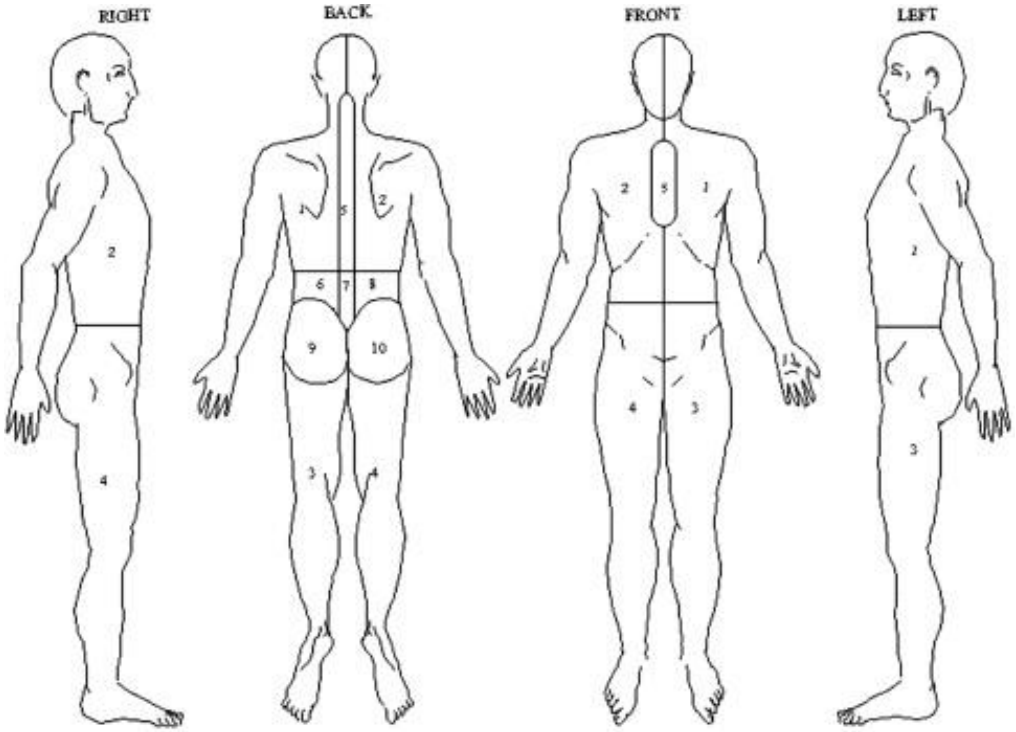
Draping will be used during the session, only the area being worked on will be uncovered. Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session or have written consent.

I,_____(print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience pain or discomfort during this session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort. I further understand that massage 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 that I am aware of. I understand that massage therapist 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 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist part if I fail to do so.

Signature of Client_____Date_____

Please continue to back side

Please mark particular area where you are experiencing tension, stiffness, pain or other discomfort:



UPDATED POLICIES

SPA ETIQUETTE

It is essential that you arrive 10 minutes prior to your first scheduled appointment. This will allow you enough time to check-in, relax, complete new client intakes and enjoy complimentary snacks and infused water in our Zen Room. Please note that your scheduled time is your table time. If you arrive late, your session will end as scheduled.

*Please Speak Softly – Brilliant Bodywork is a Quiet Healing Place

*Please Turn Cell Phones Off in Order to Keep Serenity in the Spa

*Please Respect Our Other Guests - Right to Solitude

Change/Cancellation/No-Show Policy

Our Therapists are highly trained professionals who are scheduled to serve you based upon the confirmed appointments you make. We kindly request that changes and cancellations be made within 24 hours of the reserved time. A second infraction will result in a cancel fee of 50% of the total service cost. Individuals who do not show up for a scheduled appointment without a cancellation will be subject to a 100% payment of the scheduled appointment. A credit card guarantee may be required for spa services.

Please note that prices and offerings subject to change without notice.

**We have been very blessed that this has not been an issue in the past and we thank you for your understanding and business.

a.) I understand that: There is a 24 hours' notice required for cancellation of an appointment, and that a fee of 50% of the cost of the scheduled service will be charged to me when this courtesy is not provided. I understand that missed appointments without a cancellation will be charged 100% of the service fee.

Initial _____ Date _____

b.) I understand that: I am to arrive 10 min before my scheduled appointment. (This prevents any stress in scheduling to you or the therapists. This also allows you time to have a fresh beverage, use the facilities, and relax before your session) You are here to relax and recover.

Initial _____ Date _____

c.) I understand that: I am to notify my service provider of any changes in my health care/Medical History.

Initial _____ Date _____

Client Name (printed) _____

Client Name (signature) _____

Brilliant Bodywork

Client Rights and Responsibilities

We are committed to serving you with compassion, care skill and respect. As one of our clients, you have choices, Right and Responsibilities.

YOU HAVE THE RIGHT:

- To be treated with dignity and respect
- To know the name and professional status of the person(s) serving you
- To privacy
- To confidentiality of your records
- To receive accurate information about your health-related concerns
- To know the effectiveness, possible side effects and problems of all forms of treatment
- To participate in choosing a form of treatment.
- To receive education and counseling
- To consent to, or refuse any care or treatment
- To select or change your care provider
- To review your medical record with your clinician
- To amend your medical records
- To receive an information about services and costs

YOU ALSO HAVE THE RESPONSIBILTY:

- To seek medical attention promptly
- To be honest about your medical history
- To ask about anything you do not understand
- To follow health advice and instructions
- To report and significant changes in health or medication changes
- To respect clinic policies
- To keep appointments or cancel at least 24 hours in advance
- To seek non-emergency care during normal business hours and to provide useful feedback regarding our services and policies

I authorize _____ to perform the treatments or procedures recommended. I acknowledge that no guarantees, either expressed or implied have been made to me regarding the outcome of my treatments and/or procedures.

I fully understand that it is impossible to make guarantees regarding the outcome of any medical treatments and procedures,

I understand that I am financially responsible for all amounts due for services rendered.

I also authorize the release of information to a licensed physician of the facility's choosing for the purpose of professional interpretation and establishment of treatment recommendations.

I have received a copy of my patient rights and responsibilities and this facility's clients' concern procedures.

_____ _____

Client, Parent or Guardian Signature (If child is under 18) Date

_____ _____

Reviewed By Date