EVOLVE
MASSAGE THERAPY

NEW CLIENT INTAKE FORM and CANCELLATION POLICY

Date: ____
Name: ____

Date of Birth: ____________________

Please check one: ( ) Male ( ) Female

Address: ____
City: _____________________ State: _____________ Zip: _______________
Daytime Phone #: _____________________ Evening Phone #: ____________________
Email: ____

Emergency contact: ____

Do you participate in any sports? ( ) Yes ( ) No
If yes, how often do you train? ____
Do you have a goal/race you are aiming for? ____

Present symptoms that you are experiencing:
1. ____
2. ____
3. ____

Was there an event that brought about your symptoms (e.g. car accident, fall, surgery etc.)?
Even if it was many months, or years ago, we'd like to be informed:
____
____
____

What activities aggravate the condition (e.g. standing, sitting, certain movements)?
____
____
____

Does this condition interfere with any of the following?

Work: ( ) Yes ( ) No **Sleep:** ( ) Yes ( ) No **Daily Routine:** ( ) Yes ( ) No
Please explain:

____
____

Have you experienced any of the following in the past three months:
Numbness: ( ) Yes ( ) No **Tingling:** ( ) Yes ( ) No **Swelling:** ( ) Yes ( ) No

Please explain:

____
____

Have you had X-rays or other scans taken? ( ) Yes ( ) No

Has there been a medical diagnosis? ( ) Yes ( ) No
If so, by whom? ____

Have you ever had any broken bones? ( ) Yes ( ) No
If so, where and approximately when?

____
____

Have you ever had any joint injuries? ( ) Yes ( ) No
If so, where and approximately when?

____
____

Have you had any joint replacements? ( ) Yes ( ) No
If so, where and approximately when?

____
____

Please list any surgeries that you've had over your lifetime, no matter how major or minor, we'd like to be informed:

____
____
____

145 Middle Street, Suite 1121
Lake Mary, FL 32746

(407) 412-2324
faye@evolvemassagetherapy.com

Check the following conditions that apply to you, past and present. Please add your comments to clarify any condition.

INTEGUMENTARY
( ) Fungal infections/contagious skin conditions
( ) Eczema
( ) Skin cancer
( ) Burns/scars

MUSCULOSKELETAL
( ) Osteoporosis
( ) Scoliosis
( ) Gout
( ) Dislocations
( ) Lyme disease
( ) Adhesive capsulitis/frozen shoulder
( ) Osteoarthritis
( ) Spondylosis
( ) Spondylolisthesis
( ) TMJ/jaw pain
( ) Morton neuroma
( ) Carpal tunnel syndrome
( ) Disc herniation/bulge
( ) Whiplash

RESPIRATORY
( ) Sinusitis
( ) Emphysema
( ) Bronchitis
( ) Asthma
( ) Seasonal allergies

LYMPH & IMMUNE
( ) Edema
( ) Lymphoma
( ) Allergic reactions
( ) Multiple sclerosis
( ) Rheumatoid arthritis
( ) AIDS
( ) Lupus

NERVOUS
( ) Fibromyalgia
( ) Migraine/headache
( ) Epilepsy
( ) Vertigo
( ) Peripheral Neuropathy
( ) Shingles
( ) Depression/anxiety
( ) PTSD
( ) Stroke

CIRCULATORY
( ) Embolism/thrombus/DVT
( ) Hemophilia
( ) Aneurysm
( ) Atherosclerosis
( ) Hypertension
( ) Raynaud disease/syndrome
( ) Varicose veins
( ) Cardiovascular disease

ENDOCRINE
( ) Diabetes
( ) Thyroid Disease

REPRODUCTIVE
( ) Endometriosis
( ) Breast Cancer
( ) Menopause
( ) Ovarian/menstrual conditions
( ) Prostate Conditions

*Please note that I am not certified in pregnancy massage.

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DIGESTIVE
( ) Irritable bowel syndrome
( ) Crohn's disease
( ) Hepatitis

OTHER
( ) Elective surgeries
( ) Cancer/tumors
( ) Drug/alcohol/tobacco use
( ) Contact lenses
( ) Dentures
( ) Hearing Aid

Explanations (please use the back of this form if you need more space):
____
____
____

Please list other therapies you have tried in the past and/or are presently receiving:
____
____
____

Please list any medications (including aspirin) and nutritional supplements you are currently taking: ____
____

Is there anything else about your health history that you think would be informative for your massage practitioner to know to plan a safe and effective massage session for you?
____
____

Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session. This is Florida State Law. Informed written consent must be provided by a parent or legal guardian for any client under the age of 18.

The following conditions are contraindications for massage:

1) Uncontrolled high blood pressure
2) Deep vein thrombosis
3) Blood clots
4) Phlebitis
5) Congestive heart failure

You must notify me of serious illnesses and conditions. You may be asked to bring a letter from your doctor stating that your medical condition would not be contraindication for massage.

I have stated all conditions that I am aware of and this information is true and accurate. I agree to keep the health care provider updated on my health and medical condition and understand that there shall be no liability on the therapist or Evolve Massage Therapy.

If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure can be adjusted to my level of comfort. I will not hold my therapist or Evolve Massage Therapy responsible for any pain or discomfort I experience during or after the session.

________ (Please initial)

CANCELLATION/RESCHEDULING POLICY

Note that this is required for all appointments including gift certificates, gift vouchers, etc.

Evolve Massage Therapy requires at least 24 hours notice for any cancellation or rescheduling. Please call or text Evolve Massage Therapy at 407-412-2324 anytime during normal waking hours or e-mail faye@evolvemassagetherapy.com at any time.

It is your responsibility to ensure you have received a reply from Evolve Massage Therapy to confirm cancellation BEFORE your appointment time.

If you cancel OR change your appointment:

(1) With at least 24 hours notice: No problem, no charge.
(2) Within 24 hours of your appointment for any reason: FULL charge for the session.
(3) No show, no notice. If you simply do not show up for any reason, with no notice: Evolve Massage Therapy will charge the card on file for the FULL session rate.

I authorize Evolve Massage Therapy to charge my debit/credit card for agreed upon services, or as per their above stated policies. I understand that my information may be saved to file for future transactions on my account. All information is held securely on a merchant service provider on behalf of Evolve Massage Therapy.

Client Name: ______________________________________
(Please print)

Signature: ______________________________________ Date: ____________________