



CLIENT INTAKE FORM

CORE VITAL MASSAGE THERAPY AND WELLNESS

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|--|--------|---------------------|--|
| Name | | Mobile phone Number | <input type="checkbox"/> OK to leave message |
| <input type="checkbox"/> I would like to receive SMS notifications (Please list service provider): | | | |
| Address | | City/State | Zip |
| Email Address | | | Date of Birth |
| Sex | Height | Weight | |
| How did you hear about us? | | | |
| Emergency Contact Name & Phone Number | | | |

HEALTH HISTORY

Please check all current/past conditions that apply:

| | | | |
|---|--|---|---|
| <input type="checkbox"/> active cancer | <input type="checkbox"/> diabetes | <input type="checkbox"/> irritated skin rash | <input type="checkbox"/> seizures |
| <input type="checkbox"/> arteriosclerosis | <input type="checkbox"/> dizziness | <input type="checkbox"/> jaw clenching/teeth grinding | <input type="checkbox"/> severe pain |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> epilepsy | <input type="checkbox"/> muscle joint pain | <input type="checkbox"/> stomach ulcers |
| <input type="checkbox"/> asthma | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> musculoskeletal problems | <input type="checkbox"/> stroke/heart attack |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> headaches | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> sunburn |
| <input type="checkbox"/> bruise easily | <input type="checkbox"/> hemophilia | <input type="checkbox"/> pins/pacemaker | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> cold or flu | <input type="checkbox"/> hernia | <input type="checkbox"/> poison ivy | <input type="checkbox"/> wear contact lenses |
| <input type="checkbox"/> cuts, burns, bruises | <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> pregnancy | <input type="checkbox"/> numbness/tingling, if so, where: _____ |
| <input type="checkbox"/> depression | <input type="checkbox"/> inflammation | | |

Please list any other medical conditions and/or any medications you are currently taking:

Please list any accidents, injuries and/or surgeries in the last two years and include date of occurrence:

| | | |
|---|--|---|
| Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many weeks: _____ | Postpartum two years or less? <input type="checkbox"/> Yes <input type="checkbox"/> No DOB: _____ | Do you have any allergies and/or skin sensitivities? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list: |
|---|--|---|

Do you sit for extended periods of time at a workstation, computer or while driving? Yes No

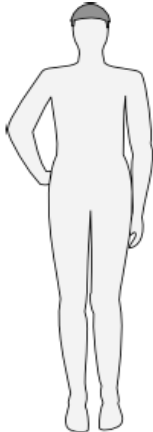
| | | |
|--|--|--------------------------------------|
| Exercise frequency: | Exercise type(s): | How much water do you drink per day: |
| Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever smoked? <input type="checkbox"/> Yes <input type="checkbox"/> No | How often: |

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No If yes, where?

Have you received professional massage before? Yes No If yes, how recently / frequently?

Do you have any particular goals in mind for this massage session? Yes No If yes, please describe:

Please mark areas of discomfort:



TERMS & CONDITIONS

BY SIGNING BELOW, I ACKNOWLEDGE AND AGREE TO ALL OF THE FOLLOWING TERMS: The studio identified below is independently owned and operated by the operator. Neither Core Vital Massage Therapy & Wellness, or any person employed by the studio are contractually or otherwise liable to any individual whom receives services at the studio or anywhere service is performed. I acknowledge and understand that the studio's massage therapist and other personnel are employees of Operator. Massage and bodywork therapy is not a replacement for medical care and no medical diagnosis will be made. Because massage and bodywork therapy may be contraindicated due to certain medical conditions, I affirm that I have informed the Studio of all known medical conditions and will keep the Studio updated as to any changes in my condition going forward. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the session may be adjusted to my level of comfort.

ASSUMPTION OF RISK, RELEASE, WAIVER OF LIABILITY, AND INDEMNIFICATION- To the fullest extent permitted by applicable law, by signing below, I hereby waive all claims, assume all risks and liability, and release, indemnify, and agree to defend Operator, Core Vital Massage Therapy & Wellness, their respective owners, officers, directors, employees, representatives, successors, and assigns (each a "Released Party"), from liability for any injury, claim, cause of action, suit, demand, and damages (each a "Claim") (including, without limitation, personal injury, economic loss, punitive damages, and consequential damages) which arises in whole or in part out of my receipt of services at the Studio or where ever services are performed, including those Claims based on any Released Party's alleged or actual negligence, breach of any contract and/or express or implied warranty, or any and all violation(s) of codes, statutes, licensing requirements or registration of the state in which the studio is located, whether known or unknown as of the date hereof. If any terms of this Assumption of Risk, Release, Waiver of Liability, and Indemnification are held to be invalid, illegal, or unenforceable, all other terms shall remain in full force and effect.

CLIENT BEHAVIOR- Any illicit or sexually suggestive comments or actions made by me will result in immediate termination of the session and I am responsible for full payment.

CANCELLATION POLICY- Appointments may be cancelled without charge any time before the close of business on the business day preceding the appointment. Cancellations made with less than 24 hours' advance notice may be charged a Late Cancellation fee up to the full cost of the booked session as determined by the studio and by signing below, I authorize Operator (and its successors and assigns) to charge my credit card or checking account on file in the event of such late cancellation.

CLIENT INFO- Please be advised your personal information (including but not limited to your visit history, buying habits, personal preferences, and the contact information you have provided on this intake Form or that you have entered into a scheduling program) will be shared with Core Vital Massage Therapy & Wellness, its therapist and employees for various purposes, including but not limited to providing, maintaining, and improving services at Core Vital Massage Therapy & Wellness studios. Core Vital Massage Therapy & Wellness privacy policy is available at www.corevitalmassage.com. The Studio complies with applicable laws that protect the privacy and security of the client's personal data.

COMMUNICATIONS POLICY- Operator, Core Vital Massage Therapy & Wellness, and/or their employees may occasionally send promotional opportunities and marketing materials via e-mail, phone calls, text messages, faxes, and other electronic messages. If you do not wish to have your contact information used to promote Core Vital Massage Therapy & Wellness products or services, you can opt-out of receiving such communications by checking the relevant box below. If Operator, Core Vital Massage Therapy & Wellness, and/or their vendors have sent you a promotional e-mail, you may send a return e-mail asking to be omitted from future e-mail communications or unsubscribe by following the link found at the bottom of the e-mail communication. Subject to applicable law, this opt-out does not apply to appointment reminders and communications about service purchases, billing information, late charges, product service experience or other transactions.

I do not wish to receive promotional opportunities

Name of Studio Operator: Core Vital Massage Therapy & Wellness

Operator/
Therapist

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| Signature | I acknowledge I have received notice of (or have been given the opportunity to review) Operators privacy and security policy. _____ (Initial here) | Date | MT initials |
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