GYROTONIC® CORAL GABLES

AN EXERCISE SPA

MASSAGE INTAKE AND AGREEMENT

Name____ **Phone** __________________

DOB_______________________

Address____

City ________________**State** ________ **Zip**__________

E-mail:
____

Referred by:____

Phone(   )__________________________

In case of emergency: ____

Phone(   )__________________________

Occupation ____

Physician____

.What are your primary goals for sessions with us?
1)____
2)____
3)____

How were you referred to us?

____

Yes No Do you frequently suffer from stress?

Yes No Do you have diabetes?

Yes No Do you experience frequent headaches?

Yes No Are you pregnant?

Yes No Do you suffer from arthritis?

Yes No Are you wearing contact lenses?

Yes No Are you wearing dentures?

Yes No Do you have high blood pressure?

Yes No Are you taking high blood pressure medication

Yes No Do you suffer from epilepsy or seizures?

Yes No Do you suffer from joint swelling?

Yes No Do you have varicose veins?

Yes No Do you have any contagious diseases?

Yes No Do you have osteoporosis?

Yes No Do you have any allergies?

Yes No Do you bruise easily?

Yes No Any broken bones in the past two years?

Yes No Any injuries in the past two years?

Yes No Do you have tension or soreness in a specific area? Please specify________________________________ ____

Yes No Do you have cardiac or circulatory problems?

Yes No Do you suffer from back pain?

Yes No Do you have numbness or stabbing pains?

Yes No Are you sensitive to touch or pressure in any area?

Yes No Have you ever had surgery? Explain below.

Yes No Other medical condition, or are you taking any medications I should know about?

Comments ____

Year of last physical exam_______

Do you have any limitations in your daily routine, work, or recreational activities?

____

Have you ever experienced a professional massage or bodywork session? Yes No How recently?_________________

What are your massage or bodywork goals?
____

If you answer "yes" to any of the following questions, please explain as clearly as possible.

Massage Therapy and Bodywork

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork 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 of which I am aware. I understand that massage/bodywork and practitioners 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/ bodywork 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 keepthe practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature____Date_______________

Practitioner Signature___________________________________Date________________

Consent to Treatment of Minor: By my signature below, I hereby authorize

______________________________________ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature____Date_________

Cancellation Policy

We understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, snowstorms, and illness are just a few reasons why one might consider canceling an appointment. In our desire to be effective and fair to all of our clients and out of consideration for our therapists' time, we have adopted the following policies:

24 hour advance notice is required when canceling an appointment.

This allows the opportunity for someone else to schedule an appointment.

If you are unable to give us 24 hours advance notice you will be charged thefull amount of your appointment. This amount must be paid prior to your next scheduled appointment.

No-shows

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show". They will be charged for their "missed" appointment and future service will be denied until payment is made.

Arriving late

Appointment times have been arranged specifically for you. If you arrive late your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for the "full" session.

Out of respect and consideration to your therapist and other customers, please plan accordingly and be on time.

WE LOOK FORWARD TO SERVING YOU.

Signature____Date_______________

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