



MEDICAL MASSAGE, YOGA THERAPY & SKIN CARE INTAKE FORM
Thank you for taking the time to fill out this confidential questionnaire to help us determine the best therapeutic program designed to fit your needs/goals. If you have any questions, please ask.

Name: _____ Date: _____
Phone: (____) _____ Cell Phone: (____) _____ Fax #: (____) _____
Wk Phone (____) _____ E-Mail: _____
Address: _____ Apt.#: _____
City: _____ State: _____ Zip: _____ Date of Birth: _____
Weight: _____ Height: _____ Do you have any children? How many?: _____
Occupation: _____ Employer _____
Employer Address: _____
How did you hear about us? _____
Emergency Contact: _____ Phone: (____) _____ Physician: _____
Relationship _____ Marital Status: M / S

Payment Policy

I, the undersigned, understand and agree to the payment policy. I acknowledge that payment for all care received is my responsibility. **Payment is due at time of service** unless other arrangements have been made in advance such as the purchase of a session/class package. We accept cash, checks and credit cards (VISA/MASTERCARD/AMEX). **I also understand that a 48-hour cancellation notice is necessary to avoid charges.**

WAIVER, RELEASE AND CONSENT

In consideration of and acceptance for my participation in any therapeutic program offered by ALIGN360, I, _____ hereby waive liability towards ALIGN360 from my participation in any therapeutic program I willingly participate in. I agree to hold harmless all other persons and entities involved and connected with ALIGN360 for any damages, physical, personal or property, which may arise from my participation in a therapeutic program. I hereby request and consent to the performance of Yoga, Bodywork, and any other modalities conducted by ALIGN360. I understand that frequently, a small amount of soreness may accompany any therapeutic treatment or protocol. I voluntarily participate in the therapeutic program and assume all risks of injury, illness and/or death. I have read the above consent and understand it.

Note: If you have any preexisting conditions that may affect your participation in any therapeutic program offered at ALIGN360, we ask that you disclose such information and that you consult a health practitioner prior to your participation.

Cancellation Agreement

We look forward to helping you at ALIGN360. The time you schedule for private or semi-private sessions is reserved just for you. Your appointment is designed for optimal results. Missed appointments will hinder your progress and/or your partners (in the case of more than one). **A fee will be charged for missed appointments or cancellations without 48 hours notification unless circumstances beyond your control arise.** I have read, understand, and agree to the cancellation agreement.

If under 18: As legal guardian of _____ we consent to the above condition.

(Client Signature) (Date)

COVID-19 HEALTH INFORMATION & LIABILITY WAIVER

- 1) Have you had a fever in the last 24 hours of 100.4 or above? Yes _____ No _____
- 2) Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath?
Yes _____ No _____
- 3) Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? (fever, cough, chills, shortness of breath, fatigue, muscle aches, or new loss of taste or smell).
Yes _____ No _____

If you answered 'Yes' to any of the questions above, you agree to go home, & seek medical advice immediately. Your appointment will be rescheduled.

Cancellation

Amid the ongoing uncertainty of COVID-19, we have modified our cancellation policy to offer greater flexibility to all our clients. We hope this will alleviate any stress and hesitation you have about an upcoming appointment. If you need to reschedule for whatever reason, and especially if you are not feeling well, we understand and request for you to please contact us as soon as possible to reschedule. To further support you, there will be no penalties for 'late cancellations' due to illness at this time.

Tardiness

Appointment times are scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please be on time to your appointment

Sickness

Massage therapy & skincare services are not appropriate treatments for infectious or contagious illness. Please cancel your appointment as soon as you are aware of an infectious or contagious condition. If it is within the 48-hour notice period, the cancellation fee may be waved.

Consent for Treatment

I understand that, because massage therapy & skin care services requires maintained touch and close physical proximity over an extended period or time, there may be elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time. I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner/business.

If under 18: As legal guardian of _____ we consent to the above condition.

(Client Signature) (Date)

NAME: _____

What is your primary goal for seeking services at ALIGN360? (Health, Fitness, Body, Spiritual)
Please detail:

Why? _____

Secondary goal? _____

How many days per week are you can you dedicate towards those goals? _____

What do you believe the function of your Manual or Movement Therapist should be? _____

Are you interested incorporating Somatic Movement or Yoga to enhance your goals? _____

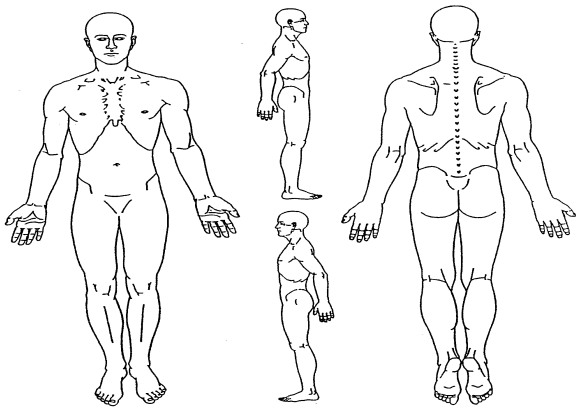
What is your general stress level (1-10)? _____ What would you like it to be (1-10)? _____

If you have been experiencing pain what is your pain level now? (1-10) _____

Indicate areas on your body that are bothering you or that you would like to improve on:

Circle the areas that tend to bother you most:

- Neck
- Lower back
- Hips
- Upper back
- Legs
- Feet
- Arms
- Knees
- Shoulders
- Between shoulder blades
- Hands/wrists



Are you currently pregnant? Yes/No ___ 1ST ___ 2ND ___ 3RD TRIMESTER

Please read over the following conditions and symptoms, check all that apply:

- ___ Easy Bruising
- ___ Open Wounds
- ___ Skin Disorders
- ___ Strains or Sprains
- ___ Diabetes
- ___ Spasms
- ___ Heart Disease
- ___ Fibromyalgia
- ___ Allergies (Please specify)
- ___ Gastrointestinal Issues
- ___ High/Low Blood Pressure
- ___ Blood Thinning
- ___ Prone to Cold Sores
- ___ Surgeries
- ___ Scoliosis
- ___ Numbness/Tingling
- ___ Foot Fungus
- ___ Varicose Veins
- ___ Tendonitis
- ___ HIV or AIDS
- ___ Herpes
- ___ Arthritis
- ___ Headaches
- ___ Seizures
- ___ Hepatitis
- ___ Osteoporosis/Osteopenia
- ___ Other Medical Conditions

Are you undergoing treatment? Yes/No

___ Cancer (Please specify type)

Are you undergoing Treatment? Yes/No ___ Radiation ___ Chemotherapy ___ Immunotherapy ___ Surgery

Node Removal Yes/No How Many? _____ Location(s) _____ Date of Surgery _____

List Current Medications _____