MEDICAL MASSAGE, FUNCTIONAL FITNESS / YOGA & 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. Your appointment is reserved for you and designed for optimal results. In order to manage our schedules, **any cancellation or reschedule made within 48 hours of your appointment will be charged the full amount for the service**. **PLEASE NOTE: medical insurance will not be billed and this will be an out-of-pocket expense.** We appreciate your help in ensuring everyone's time is respected**.** 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? _________________________

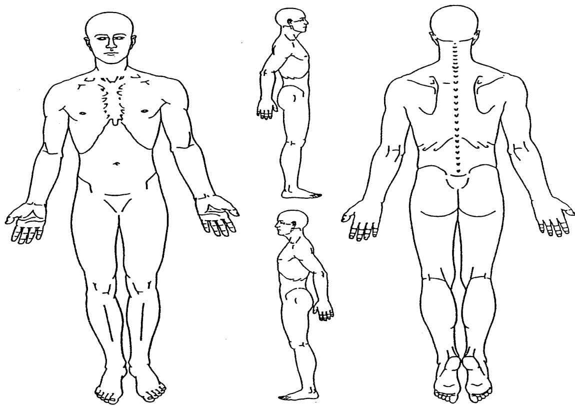
What do you believe the function of your Manual or Movement Therapist should be? _______________
____

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 Upper back Knees Shoulders
Lower back Legs Between shoulder blades
Hips Feet Arms 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*)
____
__ Cancer (*Please specify type*)
____

__ Gastrointestinal Issues
__ High/Low Blood Pressure
__ Blood Thinning
__ Prone to Cold Sores
__ Surgeries
__ Scoliosis
__ Numbness/Tingling
__ Foot Fungus
Are you undergoing treatment? Yes/No

__ Varicose Veins
__ Tendonitis
__ HIV or AIDS
__ Herpes
__ Arthritis
__ Headaches
__ Seizures
__ Hepatitis
__ Osteoporosis/Osteopenia
__ Other Medical Conditions

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

Node Removal Yes/No How Many? ____________ Location(s) _____________ Date of Surgery _______

List Current Medications ____

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