

Massage & Muscle Therapy Studio New Client Information Form

BODY ZONE SPORTS & WELLNESS COMPLEX • 3103 PAPER MILL ROAD • WYOMISSING PA 19610 • 610-376-2100 x322

Name _____ Phone (_____) _____ DOB _____

Address _____ City _____ State _____ Zip _____

E-mail: _____

Referred by: _____ Phone (_____) _____

In case of emergency: _____ Phone (_____) _____

Occupation _____ Male Female Physician _____

Health Insurance Carrier _____

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.

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

What are your massage or bodywork goals? _____

What kind of pressure do you prefer? light medium firm

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

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you frequently suffer from stress? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you bruise easily? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No Any broken bones in the past two years? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience frequent headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No Any injuries in the past two years? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have tension or soreness in a specific area?
Please specify _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from arthritis? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing contact lenses? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing dentures? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have cardiac or circulatory problems? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from back pain? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking high blood pressure medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have numbness or stabbing pains? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from epilepsy or seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you sensitive to touch or pressure in any area? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from joint swelling? | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? Explain below. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have varicose veins? | <input type="checkbox"/> Yes <input type="checkbox"/> No Other medical condition, or are you taking any
medications I should know about? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any contagious diseases? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have osteoporosis? | Comments _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any allergies? | _____ |

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 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 keep the 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.

Assumption and release of liability: The use of fitness equipment, participating in fitness programs and services, and playing contact sports such as ice hockey, soccer, field hockey, lacrosse, basketball, and others are inherently dangerous. The undersigned, on behalf of the undersigned and the undersigned's child (collectively "Participant") hereby: (1) assume the risk of personal injury, property damage, or other loss (collectively "Injuries") to the Participant arising from or related to the activities conducted and services provided at Body Zone Sports and Wellness Complex; (2) unconditionally waive, release, and discharge WRC Sports and Fitness Limited Partnership and its agents, Commonwealth Orthopedic Associates, Inc. and their agents, employees, staff members, officers, directors, partners, members (collectively the "Released Parties") from all liability, claims, or responsibility for injuries to Participant; (3) grant permission for Participant to participate in activities at Body Zone Sports and Wellness Complex; (4) unconditionally release the Released Parties from injury arising from any good faith acts or omissions in emergency situations and (5) give permission to the staff/and or sub contracted staff of Commonwealth Orthopedic Sports Medicine to evaluate and treat my child, while participating in activities at Body Zone. I agree that you may photograph and/or videotape me or my child during my activities and that you retain the right to use these visual images in future literature for Body Zone Sports and Wellness Complex without compensation to me or my child. I further agree that you may use my name, my child's name, or any testimonials made by us without limitation in advertising and promoting Body Zone Sports and Wellness Complex.

I represent that I am over the age of 18 or a parent/guardian of the minor named above, and agree that the grant and release contained therein binds me and the minor of all of its terms.

Client Signature _____ Date _____ Team/Age Group _____

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 of Parent or Guardian _____ Date _____