For Internal Use Only
Package Type:
Package #:
Referred By:

Your Key to Wellness

Client Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Medical Information

Are you taking any medications? ☐ Yes ☐ No

If yes, please list name and use:_____

_____

Are you currently pregnant? ☐ Yes ☐ No

If yes, how far along?_____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ Yes ☐ No

If yes, please explain _____

_____

What makes it better? _____

_____

What makes it worse?_____

_____

Have you had any orthopedic injuries? ☐ Yes ☐ No

If yes, please list: _____

Please indicate any of the following that apply to you.

☐Cancer	☐Fibromyalgia	☐Headaches/Migraines
☐Stroke	☐Neuropathy	☐ Sprains or Strains
☐Diabetes	☐ Blood Clots	☐ Joint Replacement(s)
☐Arthritis	☐Heart Attack	☐ Kidney Dysfunction
☐Numbness	☐High/Low Blood Pressure	

Explain any conditions you have marked above:

_____

_____

_____

_____

Medical Information

Have you had a professional massage before? ☐ Yes ☐ No

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

☐ Prenatal ☐ Hot Stone ☐ Cupping

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ Yes ☐ No

Please explain_____

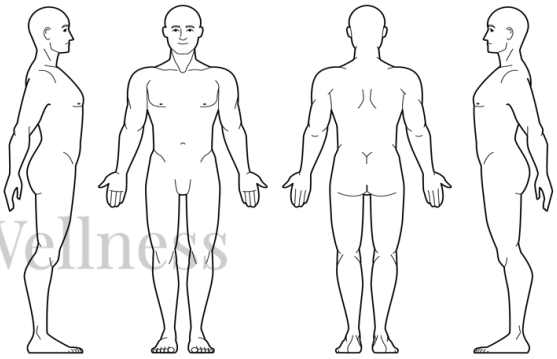
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ Yes ☐ No

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



I have completed this form to the best of my ability and knowledge and hereby agree to inform my therapist if any of the above information changes at any time.

Client Signature_____ Date_____

Therapist Signature_____ Date_____

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General Liability Release

Please take a moment to read, understand, and initial the following information:

_____ I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow

_____ I understand that the services offered are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

_____ If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.

_____ I have clearance from my physician to receive massage therapy.

_____ I understand the risks associated with massage therapy including, but are not limited to:

- Superficial bruising
- Short-term muscle soreness
- Exacerbation of undiscovered injury

I therefore release the company and the individual massage therapist from all liability concerning these injuries that may occur during the massage session.

_____ I understand the importance of informing my massage therapist of all medical conditions, existing injuries and medications I am taking, and agree to let the massage therapist know about any changes to these. I understand that there shall be no liability on the therapist's part should I forget to do so. I understand that there may be additional risks based on my physical condition

_____ I understand that massage is entirely therapeutic and non-sexual in nature.

_____ I understand that I or the massage therapist may terminate the session at any time.

_____ I have been given the Client Intake Packet containing all terms, notices, releases, and policies pertaining to the services I will be receiving. I have been given a chance to ask questions and my questions have been answered.

_____ By signing this release, I hereby agree to the above conditions of liability waive and release my therapist from any and all liability, past, present, and future relating to massage therapy.

Signature_____ Date _____

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General Policies

To provide the best service possible to our clients we have implemented the following policies.

Cancellation Policy

We respectfully ask that you provide us with a 24 hour notice of any schedule changes or cancellation requests. Please understand that when you cancel or miss your appointment without providing a 24 hour notice we are often unable to fill that appointment time. This is an inconvenience to your therapist and also means our other clients miss the chance to receive services they need. For this reason, you will be charged 30% of the session's retail value prior to any discounts. If your card is not on file, you will be required to pay the 30% fee prior to the start of your next session. We reserve the right to require a credit card number to be given to book future appointments so that appropriate fees may be charged if a late cancellation or no show does occur again.

We understand that emergencies can arise and illnesses do occur at inopportune times. If you have a fever, a known infection, or have experienced vomiting or diarrhea within 24 hours prior to your appointment time, we request that you cancel your session. Inclement weather may also result in the need for late cancellations. We will do our best to give advanced notice if we are closing or need to cancel due to bad weather and we ask you to do the same. Please do not risk your own safety trying to make your appointment. Late cancellation due to emergency, illness, or inclement weather will generally not result in any cancellation/no show charges, but this is determined on a case-by-case basis and is at the sole discretion of Schnipke Massage to Health, LLC.

Late Arrival Policy

We request that you arrive 5-10 minutes prior to your appointment time to allow time to fill out any required paperwork as well as answer any intake questions your therapist may have. We understand that issues can arise that may cause you to be late for your appointment. However, we ask that you call to inform us if this ever occurs so we can do our best to accommodate you. Appointment times are reserved for each client, so oftentimes we cannot exceed that reserved time without making the next client late. For this reason, arriving after your appointment time may result in loss of time from your massage so that your session ends at the scheduled time or a forced reschedule. Full service fees will be charged even when sessions are shortened due to late arrival. In return we will do our best to be on time, and if we are unable to do so we will add time to your session to make up for our late arrival or adjust the service charge accordingly.

Inappropriate Behavior Policy

Massage therapy is for relaxation and therapeutic purposes only. There is absolutely no sexual component to massage whatsoever. Any insinuation, joke, gesture, conversation, or request otherwise will result in immediate termination of your session and a refusal of any and all services in the future. You will be charged the full service fee regardless of the length of your session. Depending on the behavior exhibited we may also file a report with the local authorities if necessary. Treat your therapist with respect and dignity and you will be treated the same in return.

By signing below, you agree to abide by these policies.

Client Signature_____ Date_____

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Precautionary Coronavirus Liability Release

Due to the outbreak of the novel Coronavirus, COVID-19, we are taking extra precautions with the intake of each client, health history review, as well as sanitization and disinfecting practices. Please complete the following and sign below.

Symptoms of COVID-19 include:

Fever	Diarrhea	Loss of taste & smell
Fatigue	Confusion	Bruising, redness,
Dry cough	New widespread muscle	swelling, or cramping in
Difficulty breathing	pain	lower legs and feet
Chills	Headaches	
Nausea or vomiting	Red or purple toes	

I, _____ agree to the following:

- I understand the above symptoms and affirm that I, as well as all household members, do not currently have, nor have experienced the symptoms listed above within the last 14 days.
- I affirm that I, as well as all household members, have not been diagnosed with COVID19 within the last 30 days.
- I affirm that I, as well as all household members, have not knowingly been exposed to anyone diagnosed with COVID-19 within the last 30 days.
- I affirm that I, as well as all household members, have not traveled outside of the country, or to any city outside of our own that is or has been considered a “hot spot” for COVID-19 infections within the last 30 days.
- I understand that this business and my massage therapist cannot be held liable for any exposure to the virus or any other contagion caused by misinformation on this form or the health history provided by each client.

By signing below I agree to each above statement and release the massage therapist and business from any and all liability for the unintentional exposure or harm due to COVID-19.

Your massage therapist and all employees of this facility agree that they abide by these same standards and affirm the same. We also affirm that we have improved and expanded our sanitization protocols to more thoroughly fight the spread of COVID-19 and other communicable conditions.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

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Credit Card Authorization

Type of Card: ☐ VISA ☐ MasterCard ☐ DISCOVER NETWORK ☐ AMERICAN EXPRESS ☐ HSA/FSA

Name on the Card_____

Card Number: _____--_____--_____--_____

Expiration Date: _____/_____

CCV Code (three digits on back of card): _____

Cardholder Name: _____

Billing Address: _____

_____

Email Address: _____

I hereby authorize Schnipke Massage to Health, LLC to charge my card above under the terms of this of my sessions, package, and/or the cancellation/no-show policy.

Client Signature_____

Date_____

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Marketing Release

To provide transparent operation of our marketing practices
to our clients we have developed the following release.

This release is in conjunction with our website terms, conditions, & disclaimers.

With respect to content including, but not limited to photos and reviews, you hereby grant Schnipke Massage to Health, LLC and their marketing partners an exclusive, worldwide, irrevocable, royalty-free, license to use, reproduce, adapt, publish, translate and distribute on our website and marketing material for advertising purposes. Schnipke Massage to Health, LLC reserves the right to remove any of your content from their website and other marketing materials at any time, and for any reason, without notice.

Signature _____ Date _____

For Internal Use Only
Package Type:
Package #:

Session & Package Policy

To provide the best service possible to our clients we have implemented the following session and package policy terms.

Session Limitations

We are only able to do 1 hot stone massage a day. We will attempt to avoid multiple scheduling of this session type in a given day. If more than one session is scheduled in a given day, the first appointment booked will receive the session. The others will default to a therapeutic or relaxation massage or can be rescheduled.

Package Lengths

- Starter Packages are valid for 6 sessions or 6 months after your first session, whichever come's first.
- Key Packages are valid for 12 sessions or 12 months after your first session, whichever come's first.
- Once all Package sessions have been used or package expires, you must renew your package to continue receiving the discounted rate.
- Package renewals still require a deposit

Package Deposit

- Package deposits are NON-REFUNDABLE.
- Starter Package Deposit = $150
- Key Package Deposit = $300
- Package deposit will be applied to clients' sessions on a $25/session distribution rate.

Package Paid in Full

- Unlike deposit paid packages, Paid in Full packages will lock you in to either all 60 min, all 90 min, or all hot stone sessions.
- Additional sessions outside of your locked in package sessions can be purchased.
- Additional sessions will not count toward your package length.
- All additional sessions must be paid on the day of the session at your package rate.

Package Calculations

Minimum package savings are calculated by: 60 minute session savings x min membership sessions.

By signing below, you agree to abide by these policies.

Client Signature_____ Date_____

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Minor Release

To provide the best service possible to our clients we have developed the following minor release.

All persons under the age of 18 are required to have a parent or guardian fill out this form.

By signing below, you agree that you are the parent or legal guardian of the minor receiving treatment(s) at our facility. You understand that you are required to remain at the facility for the entirety of the minor's treatment(s). You will also be required, if needed, to assist the minor in preparing for his/her treatment(s). We may also request that you remain in the treatment room to supervise all interactions between the therapist and the minor.

You also agree that you have completed the Intake Form and have informed the therapist of all medical diagnoses, symptoms, medications, and complaints associated with the minor receiving treatment(s).

PLEASE PRINT CLEARLY:

I _____, certify that I am the parent or legal guardian of _____, who is _____ years of age as of today. I have completed the Intake Form for the above-mentioned minor and informed the therapist of all relevant medical history and concerns. I understand the scope of massage therapy and that it is not meant to diagnose, treat, or cure any conditions and is not a replacement for standard medical care. I give permission for my minor child to receive treatment(s) at this facility and agree to all the above terms.

Print Name _____

Signature _____ Date_____

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Mutual Medical Information Release Authorization (MMIRA)

Patient/Client Name: _____ DOB: _____

Address: _____

I, _____, hereby authorize _____ and
Patient/Client Name Physician
__Schnipke Massage to Health, LLC__ to release any and all pertinent health and medical information
Massage Therapist

pertaining to the overall health and wellness of myself, their mutual patient/client, between each other. This release of information will remain in effect until terminated by myself in writing.

Please initial each to verify that by signing this authorization you understand:

_____ I understand I am not required to complete this form as part of my new client packet unless I believe it is deemed medically necessary.

_____ I understand that by signing this authorization I am doing so voluntarily and the massage therapist may still deny service if they believe the risk is too great to the client.

_____ I have the right to receive a copy of this authorization

_____ I understand I will receive 1 copy for my physician and 1 for my records immediately after signing

_____ I understand a copy of this authorization must be delivered to my physician by me.

_____ I authorize the disclosure of my identifiable health information as described above.

_____ I have the right to terminate this authorization and revoke permission to release information. The revocation must be made in writing and will not affect information that has already been disclosed.

_____ I understand that the person to whom my medical information is disclosed pursuant to this authorization may not further use or disclose the information unless another authorization is obtained from me or unless such disclosure is required by law.

Patient Signature_____ Date_____

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