Bliss CLIENT INTAKE FORM

PLEASE *PRINT*

NAME:_____ DOB:_____

ADDRESS:_____

EMAIL: _____

OCCUPATION: _____TEL / TEXT#(S): _____+_____

LIST BELOW ANY...

- ALLERGIES AND/OR SKIN SENSITIVITIES:
- RELEVANT EXERCISE OR ACTIVITIES & FREQUENCY:
- ACCIDENTS, INJURIES AND/OR SURGERIES IN THE LAST 2 YEARS, INCLUDE GENERAL DATE OF OCCURRENCE:
- MEDICAL OR EMOTIONAL CONDITIONS, SIDE-EFFECTS YOU MAY EXPERIENCE & RELATED MEDICATIONS:

YOUR PREFERENCES – CHECK ALL THAT APPLY:

☐ NO MASSAGE OF FACE

☐ NO MASSAGE OF SCALP

☐ NO MASSAGE OF PECS

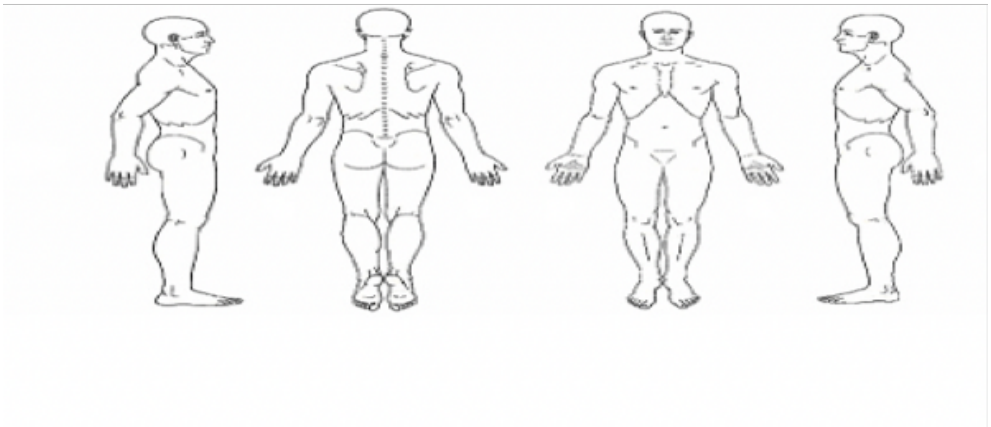
☐ NO MASSAGE OF GLUTES

LEVEL OF PRESSURE I PREFER:

☐ LIGHT ☐ FIRM

☐ MEDIUM ☐ DEEP

PLEASE CIRCLE OR PLACE AN X OVER ANY AREAS OF DISCOMFORT, TENSION OR WHERE YOU'D LIKE PARTICULAR FOCUS DURING YOUR MASSAGE SESSION.



PLEASE READ EACH POLICY & INDICATE YOUR UNDERSTANDING BY INITIALING:

Illness Policy: If you are currently experiencing a cold, flu or fever, your session MUST be rescheduled for 48 hours after symptoms subside. **INITIALS: _____**

Cancellation Policy: By signing this intake form you agree that if you need to cancel or reschedule an appointment, you will provide Sara Bliss with a minimum of 24 hours' notice to avoid being charged a fee. Any cancellations within 24 hours of your scheduled time will be subject to the current cancellation fee of $30.
INITIALS: _____

ZERO TOLERANCE POLICY: CLIENT UNDERSTANDS THAT SUGGESTIVE LANGUAGE, INUENDO OR INQUIRIES, AND/OR SEXUAL, SUGGESTIVE OR INAPPROPRIATE BEHAVIOR BY CLIENTS- WILL NOT BE TOLERATED. CLIENT UNDERSTANDS THAT IF ANY OF THE ABOVE CIRCUMSTANCES ARISE DURING THE SESSION-- SESSION WILL BE IMMEDIATELY TERMINATED, CLIENT WILL BE LIABLE FOR PAYMENT OF THE FULL SESSION TIME, AND WILL BE BLOCKED FROM FUTURE VISITS. **INITIALS: ____**

MASSAGE THERAPY INFORMED CONSENT PLEASE READ, SIGN & DATE:

I understand that the massage 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 therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 that I am aware of. I understand that massage therapists 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 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 understand that I am receiving massage therapy at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy I hereby hold harmless and indemnify the therapist, her principals, and agents from all claims and liability whatsoever. **I AGREE TO ABIDE BY THE ABOVE OUTLINED POLICIES:**

Signature: _____Date: _____