



Service Date: _____
Service Time: _____

Brooks Massage Therapy Intake Form

Name: _____ M | F D.O.B. _____

EMAIL: _____

PHONE: _____ **CELL PHONE:** _____

Returning Client Y | N Referred by: _____

Have you ever had any injuries (broken bones, torn ligaments, surgeries)? When?

Do you have any of the following medical conditions

- | | | |
|---|---|---|
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Diseases | <input type="checkbox"/> Skin disorders |
| <input type="checkbox"/> Infections | <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Heart conditions |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Elective Surgery |
| <input type="checkbox"/> Other (Please explain) | | |

What medications are you currently taking?

Do you have any allergies or sensitivities to oils, lotions, scents or foods?

What are the appropriate areas of concern?

- | | | | |
|---|-------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Upper Back | <input type="checkbox"/> Knees | <input type="checkbox"/> Legs/Thighs |
| <input type="checkbox"/> Neck/Shoulders | <input type="checkbox"/> Lower Back | <input type="checkbox"/> Feet/Ankles | <input type="checkbox"/> Other |

Additional Comments:



Service Date: _____
Service Time: _____

Brooks Massage Therapy Consent Form

By signing this consent form, I understand that Brooks Massage Therapy Inc. Practitioners DO NOT diagnose illness, disease or any other medical disorder. As such, practitioners DO NOT provide medical treatment or pharmaceuticals. I understand that any services provided are not a substitution for medical treatment and that I should see a physician for any physical ailment that I might have. Because practitioners must be aware of any existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep practitioners updated on my physical health. Therefore, I assume all risk for my health and hold harmless Brooks Massage Therapy Inc. and any associated business entities, practitioners, Amenities or any persons involved in services performed.

I also understand that any illicit or sexually suggestive remarks or advances made by me in the spa at any point will result in immediate termination of the session and or removal from the spa. In this case I will be held liable for payment "In full".

I acknowledge Brooks Massage Therapy Inc. maintains a 4 hours Cancellation policy. Thus, Brooks Massage Therapy Inc. has my authorization to keep my credit card on file in case I cancel less than 4 hours prior to service date. If I choose to cancel services in less than 4 hours, I am responsible for the full amount of the service fees.

I understand that questions about service procedures and recommendations are encouraged and welcomed.

Signature: _____

Print Name: _____

Date: _____

Manager Signature: _____