



## Massage Paperwork

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Wireless Provider (for confirmations): \_\_\_\_\_

Do we need to be discreet with messages? **Y** **N**

Email Address: \_\_\_\_\_

How did you hear about us?

**Family Savings Facebook Fort Knox Google Client Referred**

**Drive-By Employee Referred Social Media Other:** \_\_\_\_\_

### Employment Information

Company Name: \_\_\_\_\_

Company Address: \_\_\_\_\_

Company Telephone Number: \_\_\_\_\_

### Emergency Contact Information

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Phone: \_\_\_\_\_

## Massage Information

Have you ever received a massage before? **Y** or **N**

What kind of pressure do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving a massage?

(Example: To relieve stress, pain, stiffness, numbness/tingling, swelling, etc.)

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How do you feel today? \_\_\_\_\_

Do these symptoms interfere with your activities of daily living? **Y** or **N**

If yes, explain:

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List the medications you currently take:

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Are you wearing contacts? **Y** or **N**

Are you wearing dentures? **Y** or **N**

Are you wearing a hair piece? **Y** or **N**

Are you pregnant? **Y** or **N**

If so, how far along are you? \_\_\_\_\_

## Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?

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Circle any of the following health conditions that you currently have:

**Blood Clots Contagious Diseases Pilled Edema Infections Congestive Heart Failure**

Please indicate conditions that you have or have had in the past.

Explain in detail, including treatment received:

**Current Past Muscle or joint pain:** \_\_\_\_\_

**Current Past Muscle or joint stiffness:** \_\_\_\_\_

**Current Past Numbness or tingling:** \_\_\_\_\_

**Current Past Swelling:** \_\_\_\_\_

**Current Past Bruise easily:** \_\_\_\_\_

**Current Past Sensitive to touch/pressure:** \_\_\_\_\_

**Current Past High/low blood pressure:** \_\_\_\_\_

**Current Past Stroke and/or heart attack:** \_\_\_\_\_

**Current Past Varicose veins:** \_\_\_\_\_

**Current Past Shortness of breath, asthma:** \_\_\_\_\_

**Current Past Cancer:** \_\_\_\_\_

**Current Past Neurological (MS, Parkinson's, chronic pain)** \_\_\_\_\_

**Current Past Epilepsy, seizures:** \_\_\_\_\_

**Current Past Headaches, migraines:** \_\_\_\_\_

**Current Past Dizziness, ringing in the ears:** \_\_\_\_\_

**Current Past Digestive Conditions (Crohn's, IBS):** \_\_\_\_\_

**Current Past Gas, bloating, constipation:** \_\_\_\_\_

**Current Past Kidney disease, infection:** \_\_\_\_\_

**Current Past Arthritis:** \_\_\_\_\_

**Current Past Osteoporosis, degenerative spine:** \_\_\_\_\_

**Current Past Scoliosis:** \_\_\_\_\_

**Current Past Broken bones:** \_\_\_\_\_

**Current Past Allergies:** \_\_\_\_\_

**Current Past Diabetes:** \_\_\_\_\_

**Current Past Endocrine/thyroid conditions:** \_\_\_\_\_

**Current Past Depression/anxiety:** \_\_\_\_\_

**Current Past Memory loss, confusion:** \_\_\_\_\_

**Any other health conditions that are not listed?** \_\_\_\_\_

## Consent for Treatment

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/body work 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/body work 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 of my 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. Understanding all of this, I give my consent to receive care.

**Client Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Parent or Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### **Refund Policy**

BodyRx offers NO refunds or exchanges on any products or services.

### **Financial Policy**

All services require payment prior to services being rendered. Insure you have correctly answered the prescreen questions if you are a weight loss client to avoid paying for a service you do not qualify for.

### **NO CHECKS, NO HEALTH SAVINGS ACCOUNT, NO FLEXIBLE SPENDING ACCOUNTS**

### **Tardiness**

Appointment times for massage are as scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please be on time for your appointment.

If arrival is delayed for spa services, we will make every effort to accommodate your appointment, but this is not always possible. Service time may be abbreviated to avoid delays for other guests as treatments are charged at the full value. Appointments missed by 15 minutes or more are cancelled with a 100% spa credit for the treatment amount missed, which is yours to use once your treatment is rescheduled.

### **Sickness**

Massage/Bodywork is not appropriate care for infectious or contagious illness. Please cancel or reschedule your appointment as soon as you are aware of an illness.

### **Cancellation Policy**

BodyRx Louisville enforces a **24-hour cancellation policy** for ALL appointments.

In order to reschedule your appointment, you must notify BodyRx at (502)882-8680/(502) 974-3447 **24 hours** before your scheduled appointment time to avoid being charged a **\$50 cancellation/no show fee**. If you fail to show up to the scheduled appointment or cancel within 24 hours, we are hereby authorized to initiate entries to the debit/credit card account that is on file. If you do not have a card saved on file, please understand that you will receive a bill and that the fee must be paid prior to scheduling another appointment.

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Signature

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Date