restore
TOTAL BODY • CLINICAL MASSAGE

Intake:

Contact Information

Name: ____
Phone: (h) _______________ (w) __________________

Address: ____________________________________
City: ____________________ State: ______ Zip:_______________

Employer: ___________________________________
Occupation: _____________________
E-mail :___________________

Circle one: Male / Female Height: ____________ Weight: ______________ D.O.B.: ___________________

In Case of Emergency: __________________________________ Phone: ______________ Relationship _______________

Referred by: ______________________ Primary Complaint: ____

Existing Medical Conditions:

Are you currently under the care of a Physician? If yes, name the Physician and reason:

____

Are you currently taking any medications? If yes, name and amount:

____

Please read carefully and check the appropriate boxes:

☐ I understand the Restore Total Body cancellation policy, as follows:

At The Restore Total Body, we value you as a friend and client. We strive to provide a relaxing, educating, and healthy atmosphere. Our therapists treat everyone with respect and trust, and so deserve the same in return. They work a limited number of hours each week to ensure the best possible care. Under these conditions, the clinic must reserve the right to charge the full fee for a missed appointment with less than twenty-four (24) hours notice. We will use our discretion when charging "No Show" fees. Also, the right is reserved by the clinic to charge the full scheduled fee for tardiness of appointments.

☐ My credit card is on-file with Restore Total Body (if not, please enter card info below)

☐ DISCOVER/VISA/MC # Exp. /

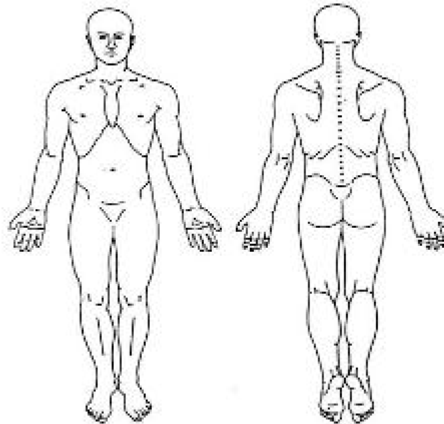
☐ I understand that my credit card WILL NOT be charged until after the time of my massage. I will have the option whether or not to bill my credit card on the date that I have scheduled the appointment.

Recommendation may be given by the Therapist with reference to future treatments, activities, occupational and sleep mechanics. The Therapist neither diagnoses illnesses, disease or any other physical or mental disorder, nor performs any spinal manipulations. *At times, one may feel some post-therapy tenderness due to the release of toxins and/or the lengthening of connective tissue.*

☐ I understand that the massage services provided by this licensed Massage Therapist are provided pursuant to and in accordance to the laws of the City of Boston governing massage therapy and that a full and complete medical disclosure is essential in providing such therapy. I agree to hold harmless, release and indemnify this massage establishment against any and all liability arising from the application of massage therapy. By signing this release form, I hereby declare that I have provided the Massage Therapist with all relevant information necessary for the proper application of massage therapy and I expressly give my permission for this Massage Therapist to provide such therapy.

Signature: Date:

Please take a minute to highlight areas of chronic tension, discomfort, or pain; on the diagram below:



1. What are your goals for today's visit?

2. When was the onset of your condition/injury/discomfort (if any)?

3. Is the condition getting progressively worse? Y____ N_____

4. On a scale of 1-10, how would you rate your pain over the last 48 hours?

At best____ At worst____ Now____

5. Are there any activities that make the condition better or worse?

6. Are there any limitations caused by the injury/condition? Y_____ N_____ (if yes, please describe)

____

____

7. Do you have any previous injuries that should be known; and do they relate to what you are being treated for today?

____

____

8. Are you under any medical/therapeutic treatment? (Y/N)

i.e.: Physical Therapy _____

Chiropractor _____

Acupuncture _____

9. Have any diagnostic tests/exams been completed for this condition?

X-ray____ MRI_____ CT Scan _____ EMG (nerve test)_____

10. Are there any areas, in particular, that you would like your therapist to focus on or stay away from?

Signature:___________________________________ Date:______________________