MASSAGE INTAKE FORM

Name: _____ Phone: _____

Email: _____

Address: _____ City/State/Zip: _____

Occupation: _____ DOB: _____

Emergency Contact: _____ Phone: _____

Referred By: _____

Why are you seeking massage therapy? _____

What type of massage are you seeking? (please circle) Relaxation OR Therapeutic/Deeper tissue

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General Medical Information (This will be discussed and clarified with your therapist before treatment)

Have you received massage before today? Y N If Yes, how long ago? _____

Are you currently pregnant? Y N If Yes, How many weeks? _____

Are you wearing contacts or prosthetics? (circle one) Y N Location of prosthetic: _____

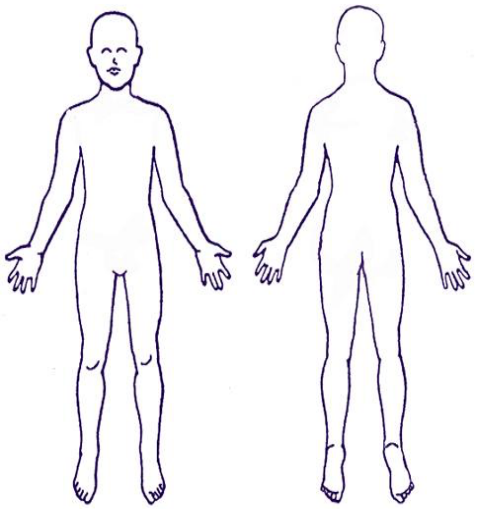
Are you currently on any medications? Y N If Yes, explain: _____

Do you currently see a Chiropractor? Y N If Yes, how often? _____

Do you have a history of:

___ Neck pain or Whiplash
___ Back pain- Mid / Low / Disc Problems / Surgeries
___ Headaches / Dizziness / Seizures
___ HIV/Diabetes / Varicose Veins
___ Sprains/Broken Bones / Joint Aches / Decreased Range of Motion
___ Allergies – Oils / Perfumes / Detergents / Other _____
___ Abdominal Pain
___ Arthritis / Bursitis / Gout
___ High Blood Pressure / Stroke / Cancer / Heart Attack
___ Cardiovascular Disease
___ Cosmetic Surgery
___ Any other Surgeries
___ Burns / Bruises
___ Any other condition past or present treated by a physician

Please identify current problem areas with an X



Do you have any of the following today?

___ Sunburn
___ Inflammation
___ Severe Pain
___ Cold / Flu
___ Headache
___ Open cuts / bruise / burn
___ Irritated skin / rash
___ Other condition / concern _____

Please read the following and sign below:

I understand that my therapist needs my current health status in order to treat me effectively. If there are any changes to my health at any time while I am a client I will inform my therapist of these changes as they occur. I understand that massage is not a replacement of medical care and that no diagnosis will be made.

Client (or Guardian) Signature: _____ Date: _____

COMPLEMENTARY AND ALTERNATIVE HEATLH CARE CLIENT BILL OF RIGHTS

THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY.

Under Minnesota law, an unlicensed health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, athletic trainer, or any other type of health care provider, the client may see such services at any time.

The following is the procedure for filing complaints with a supervisor: Protégé Fitness Studios

Supervisors Name:	**Business Address:**
Barb Lass/Scott Kratochvil	7245 University Ave NE
Phone: 763-710-9087	Fridley, MN 55432

Any client may file a complaint with the following office:

Name: Office of Unlicensed Complementary and Alternative Health Care Practice

Address: Minnesota Department of Health
P.O. Box 64975
121 East 7th Place, Suite 400
St. Paul, MN 55164-0975

Phone Number: 651.282.6319 or 1.800.657.3957

Practitioner fees for unit of services: All sessions will be on a client basis. If your insurance does pay for massage it is the responsibility of the client to get reimbursed from insurance. Other discounts will apply for packages and other promotions, ask your therapist about current specials. **Tax is not included in the listed prices. Tips are also welcome**.

Clients have a right to reasonable notice of changes in services or charges: At least a one-month notice will be posted before a fee increase is implemented.

The following is a brief summary, in plain language, of the theoretical approach used by the practitioner in providing services to the clients: I will interview my client to determine the best treatment plan for them. Once a plan and treatment goals are discussed I will use various massage modalities and techniques to: promote overall relaxation, increase motion, improve function, decrease pain, decrease stress, increase circulation and promote total body wellness.

- Clients have a right to complete and current information concerning the practitioner's assessment and recommended service that is to be provided, including the expected duration of the service to be provided.
- Clients may expect courteous treatment and to be free from verbal, physical, or sexual abuse by the practitioner.
- Client records and transactions with the practitioner are confidential, unless release of these records is authorized in writing by the client, or otherwise provided by law.
- Clients have a right to be allowed access to records and written information from records in accordance with Minnesota Statute 144.335.
- Clients have the right to choose freely among available practitioners and to change practitioners after services have begun, within the limits of health insurance, medical assistance or other health programs.
- Clients have the right to coordinated transfer when there will be a change in the provider of services.
- Clients may refuse services or treatment, unless otherwise provided by law.
- Clients may assert the client's rights without retaliation.

Subd. 2. [ACKNOWLEDGMENT BY CLIENT.] Prior to the provision of any services, a complementary and alternative health care client must sign a written statement attesting that the client has received the complementary and alternative health care client bill of rights.

I hereby acknowledge receipt of the Client Bill of Rights and the attached documents incorporated therein, and I have had a full opportunity to ask questions I have about this document and my rights as a client. I understand my rights as a client.

Printed Name, Signature, Date _____

General Liability Release Form

By signing below, you agree to the following:

- I give my permission to receive massage therapy.
- I understand that therapeutic massage is not a substitute for traditional medical treatment or medications.
- I understand that the massage therapist does not diagnose illnesses or injuries, or prescribe medications.
- I have clearance from my physician to receive massage therapy.
- I understand the risks associated with massage therapy include, 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.

6) I understand the importance of informing my massage therapist of all medical conditions and medications I am taking, and to let the massage therapist know about any changes to these. I understand that there may be additional risks based on my physical condition.
7) I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so he/she may adjust accordingly.
8) I understand that I or the massage therapist may terminate the session at any time.
9) I have been given a chance to ask questions about the massage therapy session and my questions have been answered.

_____ _____

Signature Date