INTAKE FORM

The information requested will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all the information provided below will be kept confidential. Your written permission will be required to release any information.

Name:	Phone:
Address:	City:
Postal Code:	Email (Appointment Reminders):
Emergency Contact:	
Phone:	Relationship:

DISCLAIMER

- I understand that massage therapy, reflexology, osteopathy, fascial stretch therapy and other soft tissue procedures involve the manipulation of soft tissues, bones and joints of the body to develop, maintain, rehabilitate, improve physical function, or relieve pain.
- I understand that Kaizen Health Group will not be held liable for any injury or condition that arises from my treatment, despite the completion of this form.
- I acknowledge that this information is confidential and intended for review only by staff members of Kaizen Health Group
- I recognize that each session includes time for assessment, treatment, homecare instructions, and time to undress/redress.
- I consent to my treatment, and I understand that I can change or terminate my treatment at any time, but that I will be liable to pay, at minimum, the cost of the originally booked session.
- I understand that I am responsible for any charges incurred during my treatment.
- I also understand that any illicit or sexually suggestive remarks of advances made by myself will result in immediate termination of the session, and I will be liable for full payment of the appointment.
- I am aware that 24 hours' notice is required to reschedule. Any appointments cancelled on the same day will be subject to a fee that is equal to the cost of service.

CONSENT

I hereby request and consent to the performance of massage therapy, reflexology treatment, osteopathy, and other soft tissue procedures, including various forms of massage therapy, hydrotherapy, range of motion and orthopedic testing by the therapist.

I understand that I will have the opportunity to discuss my treatment with my therapist. I also understand that results are not guaranteed. I further understand and am informed that in the practice of massage therapy, osteopathy, reflexology, and other soft tissue procedures, as in all health care, there are some slight risks to the treatment, including but not limited to: muscle tenderness, stiffness, and sometimes bruising. I do not expect the therapist to be able to anticipate all the risks and complications associated with my treatment. I wish to rely on the therapist to exercise judgement during my treatment(s) to apply the methods which they feel at the time, based on the facts known, and are in my best interest.

By signing below, I am signifying my agreement to massage therapy, reflexology, osteopathy and other soft tissue procedures and I intend this consent to apply to and cover the entire course of my treatment(s) with Kaizen Health Group.

CANCELLATION POLICY

Kaizen Health Group has a 24-hour cancellation policy to reschedule or cancel any appointments. Appointments cancelled with less than 24 hours' notice are subject to a cancellation fee equal to the cost of service. I understand that when booking an appointment, I am not only booking the service, but the time required to complete my service.

By signing below, I understand that I am responsible for cancelling or rescheduling my appointments with a minimum of 24 hours' notice. Failure to provide adequate notice may result in a late cancellation fee (as described above) and/or a credit card requirement to secure future appointments.

Patient Signature:	Date:
If a minor, signature of Guardian/Parent:	Date:

Health History Form

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name:	Date of Birth:

Have you received massage therapy before? ☐ Yes ☐ No

Did a health care practitioner recommend treatment? ☐ Yes ☐ No

Please indicate conditions you are experiencing or have experienced:

Cardiovascular	**Infections**	**Head/Neck**
☐ High Blood Pressure ☐ Low Blood Pressure ☐ Chronic Congestive Heart Failure ☐ Heart Attack ☐ Phlebitis/Varicose Veins ☐ Pacemaker or Similar Device ☐ Heart Disease	Do you have any infections that would affect your massage treatment or require your treatment to be postponed? ☐ Yes ☐ No	☐ History of Headaches ☐ History of Migraines ☐ Vision Problems ☐ Vision Loss ☐ Ear Problems ☐ Hearing Loss
Respiratory	**Women's Health**	**Current Medications:**
☐ Chronic Cough ☐ Shortness of Breath ☐ Bronchitis ☐ Asthma ☐ Emphysema	⚠ Only complete this section if condition(s) affects your Massage Therapy Care. ☐ Pregnant, Due: _____ ☐ Gynecological Conditions: _____ _____	⚠ Only complete this section if condition(s) affects your Massage Therapy Care. ☐ Current Medications: _____ _____ ☐ Condition(s) It Treats: _____
Digestive Conditions	**Surgeries & Injuries**	**Allergies**
⚠ Only complete this section if condition(s) affects your Massage Therapy Care. ☐ Yes ☐ No If so, What? _____ _____	⚠ Only complete this section if condition(s) affects your Massage Therapy Care. Surgery: _____ Surgery Date: _____ ☐ Artificial Joints ☐ Special Equipment ☐ Internal Pins ☐ Wires	⚠ Only complete this section if condition(s) affects your Massage Therapy Care. Allergies: _____ Type of Reaction: _____ Medication(s): _____

Other Conditions

⚠ Only complete this section if condition(s) affects your Massage Therapy Care.

Do you have any other conditions that are not listed on this intake form but are relevant to your massage therapy care? ☐ Yes ☐ No

If yes, what? _____

By Signing Below, I confirm that the information I've provided has been updated to the best of my knowledge. I also confirm my responsibility to inform my therapist of any new or developing conditions that may affect the safety and efficacy of treatment that may arise in the future.

Signature of Patient or Guardian (if minor): _____ Date: _____

kaizen H. G.
MASSAGE & WELLNESS