



Massage Therapy & Energy Healing Client Intake Form

Welcome to Synergy Wellness Center! In order to provide the best possible service for you, we ask that you complete this Intake Form so we can gear your Massage and/or Energy Healing treatment to your individual needs and wishes.

Full Name: _____ DOB: _____

Mailing Address: _____

Phone: _____ Email: _____

Emergency contact (name, phone): _____

Occupation: _____ Do you sit or stand for long periods? Yes No

How did you hear about us? _____

If referred, by whom? _____

Have you had a professional massage before? Yes No

What are you goals with Massage Therapy? (please circle all that apply)

Relaxation Greater range of motion Greater flexibility

Stress relief Reduce pain Not sure

Are you sensitive to essential oils? Yes No

Medical History

Various medical conditions can impact how your body receives massage. All the information on this form as well as any additional information you provide to Synergy Wellness Center is held in the strictest of confidence and you may view your record upon written request.

Do you exercise? Yes No If so, how often and what activities? _____

Do you wear contact lenses? Yes No Do you wear a hearing aid? Yes No

Please list any current medications (including aspirin, ibuprofen, herbs, supplements, etc)

Allergies: _____ Surgeries: _____

Musculoskeletal:

Osteoporosis	Bone Pain	Adhesions	Incisions	Headache
Pain	Fractures	Joint Problems	Joint Replacement	Injury
Arthritis	Touch Sensitivity	Range of Motion	Spasms/Cramps	Walking Issues
Jaw Pain/TMJ	Tendonitis	Bursitis	Scoliosis	Bone/Joint Disease

Nervous System:

Dizziness	Memory Issues	Numbness	Tingling	Face Twitches
Fatigue	Chronic Pain	Sleep Disorder	Ulcers	Paralysis
Herpes/Shingles	Cerebral Palsy	Epilepsy	Chronic Fatigue	Multiple Sclerosis
Musc. Dystrophy	Parkinson's	Spinal Cord Inj.		

Skin:

Rashes	Skin Allergies	Athlete's Foot	Surgeries	Infection
Irritation	Dry Skin	Sensitive Skin	Bruising/Bleeding	

Digestive:

Nausea/Vomiting	Colitis	Appetite Change	Diarrhea	Constipation
Indigestion	Bloating	Diverticulitis	IBS	Crohn's Disease

Circulatory & Respiratory:

Dizziness	Short of Breath	Fainting	Cold Hands/Feet	Sweats
Edema (swelling)	Varicose Veins	Blood Clots	Stroke	High Cholesterol
Heart Condition	Allergies	Sinus Issues	Asthma	High Blood Pr.
Low Blood Pr.	Lymphedema	Pacemaker	Arrhythmia	HIV/AIDS

Reproductive System:

Pregnancy	PMS	Perimenopause	Menopause	Pelvic Inflammatory Disease
Endometriosis	Hysterectomy	Fertility Concerns	Prostate Issues	

General:

Drug Use	Alcohol Use	Caffeine Use	Nicotine Use	Appetite Loss
Hearing Impaired	Burning Upon Urination	Bladder Infections	Eating Disorder	Diabetes
Fibromyalgia	Post-Polio Syndrome	Cancer Type:	Hyper/Hypothyroidism	Hepatitis
Insomnia	Depression	Anxiety	Lymph Node Biopsy/Removal	Tension/Stress
Hernia	Kidney/Urinary	Liver/Gall Bladder	Lyme Disease	Recent Surgery

- Have you had a fever in the last 24 hours of 100°F or above?
- Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath?
- Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms?

Please list any other conditions, syndromes, recent accidents and additional comments regarding your health status:

Release Form:

I understand that the massage/energy therapy that I receive is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension. 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/energy therapy should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware.

Because massage/energy therapy is contraindicated under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered questions honestly. I agree to

keep Synergy Wellness Center updated as to any changes in my medical profile and understand that there shall be no liability on the part of Synergy Wellness Center should I fail to do so. Should I need to cancel future sessions, I agree to give my practitioner 24 hours notice or I will be financially responsible for the session time.

I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage and bodywork from this practitioner. Please be prepared to let us know at the beginning of your session what you would like to have addressed in your body work treatment.

I further acknowledge that I am voluntarily participating in the above referenced activities with the full knowledge and understanding that said activities are taking place during the COVID-19 pandemic. I understand that while Synergy Wellness Center LLC and its employees and contractors will abide by all local, state, and federal government laws and guidelines, as well as CDC guidelines, in an attempt to keep employees and guests safe, that I assume ALL risks associated with participation in said activities during said pandemic, including but not limited to: any illness and any adverse physical and/or psychological effects from the same and/or loss of any income or other monetary loss incurred as a result of the effects of said illness and/or costs incurred in the treatment of the same. I accept full and total responsibility for my own health and agree to release, hold harmless, and indemnify, to the extent permitted by the law, Synergy Wellness Center LLC, its employees and contractors from any liability for any illness, injury, loss or damages I may incur as a result of contracting COVID-19 as a result of engaging in said above referenced activities.

I have read, understand, and agree to the content of this Agreement and voluntarily agree to the terms and conditions stated above.

Client Signature: _____ Date: _____

Practitioner: _____ Date: _____

Parent/Legal Guardian of Minor Under Age 18: _____ Date: _____