



UNITY HEALING SPA
INTEGRATIVE MASSAGE & SPA

WELCOME TO UNITY

Thank you for taking the time to complete this personal care guide.
Your responses will help with accommodating your needs with your unique experience.
Be Heard and Be Whole!

Client Intake Form

General Information

Name _____ Email _____

Phone _____ ZIP Code _____ DOB _____ Gender _____

Occupation _____ Emergency Contact # _____

Medical Information

This information is to give you the safest and the most beneficial massage possible.

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have varicose veins? | <input type="checkbox"/> Yes <input type="checkbox"/> No Any autoimmune conditions? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you bruise easily? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any contagious disease? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from arthritis? | <input type="checkbox"/> Yes <input type="checkbox"/> No Any numbness or tingling sensations? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience joint swelling? | <input type="checkbox"/> Yes <input type="checkbox"/> No Any electrical or burning sensations? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Have you broken bones in the past year? | <input type="checkbox"/> Yes <input type="checkbox"/> No Any major injuries during your lifetime? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you sensitive to pressure in any areas? | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Any history of aneurysms or embolisms? | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any allergies? List in comments. | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any patches, ports, or implants? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have Diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have cancer? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you on any medications, herbs, etc.? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have heat or cold intolerance? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have osteoporosis? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any heart related conditions? |

If you have any other medical conditions, any additional information, or anything that could be relevant then please put this information in the comments section.

Comments: _____

Client Signature _____ Date _____



Appointment Policies

Initialing means that you understand and agree to the policy rule.

Cancellation Policy

We respectfully ask that clients provide a 24-hour notice of any schedule changes, cancellation requests, or appointment modifications. Appointments cancelled or appointment time changed less than 24-hours before the scheduled appointment will be treated as a "last minute cancellation". Exceptions for emergencies will be granted on a case-by-case basis.

Initial _____

No Shows/ Last Minute Cancellations/ Ongoing Cancellations

Any no-shows/ last-minute cancellations/ ongoing cancellations will be given two options to choose from. The first option is to pay for 50% of the appointment missed. The other option is to buy a package and prepay for future appointments until/unless restrictions are lifted.

Initial _____

Holiday Weeks

During the weeks of Christmas, New Years, Thanksgiving, and Memorial/Labor Day, cancelling a scheduled appointment will be treated as a "last minute cancellation". An exception may be given if the appointment is cancelled two weeks in advance.

Initial _____

Session time

I understand that I should arrive 5-10 minutes early to my appointment for the best treatment; session time will not be extended if I arrive late.

Initial _____

Yes **No** May you be contacted via email and/or text regarding your appointment?

Yes **No** May you be contacted via email and/or text for promotions and offers?

Client Signature _____ Date _____



Informed Consent Form

Initialing means that you understand and agree with the information stated.

I understand what the following techniques/tools are: effleurage, kneading, friction, percussion, vibration, stretching, static cupping, dynamic cupping, gua sha, Ashiatsu, hot stones, cryotherapy, ice, hot bamboo, foam rolling, hot towels, massage guns, acupressure seeds, acupressure, acupressure tools, hydrotherapy, and medical/visceral massage. I consent to being treated with the aforementioned techniques/tools and have asked for clarification for any techniques/tools that I do not fully understand.

Initial _____

I understand that massage and body work therapist are not medical doctors. Massage and body work therapist are not trained to diagnose medical diseases nor conditions. I will contact my primary health care provider for diagnosis of medical diseases and conditions.

Initial _____

It is my responsibility to keep my therapist updated on any medication changes and any medical changes. This includes but is not limited to things such as taking over the counter medications (e.g., pain relievers), feeling feverish, being diagnosed with a illness/condition/disease by a primary care provider, and being recently ill with something contagious.

Initial _____

Information exchanged during a massage or bodywork session is confidential. Because of this, I understand that my feedback during treatment is essential. If I experience any pain or discomfort during a session, I will immediately notify my therapist so that I can receive the best treatment possible.

Initial _____

Treatment may be terminated during the session if any sexual misconduct occurs. If this occurs, I will be liable for full payment of the scheduled session.

Initial _____

I have not thoroughly read through this information and require it read out to me. This part will be initialized by me again and signed off by my therapist after being read out by my therapist. If I have read the information thoroughly and understand all stated in this document, then I will not initial for this statement. If I have any questions and/or need clarification, then I will ask my therapist to help clarify.

Initial _____

Client Signature _____ Date _____

