



# Patti and Allan Herbert Wellness Center Massage Therapy Intake Form

## Personal Information

Name \_\_\_\_\_ Phone (day) \_\_\_\_\_ (evening) \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_ DOB \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Email \_\_\_\_\_ Primary Physician \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

## Medical Information

Are you taking any medications?  yes  no  
If yes, please list name and use: \_\_\_\_\_  
\_\_\_\_\_

Are you currently pregnant?  yes  no  
If yes, how far along? \_\_\_\_\_  
Any high risk factors? \_\_\_\_\_

Do you suffer from chronic pain?  yes  no  
If yes, please explain \_\_\_\_\_  
What makes it better? \_\_\_\_\_  
\_\_\_\_\_  
What makes it worse? \_\_\_\_\_  
\_\_\_\_\_

Have you had any orthopedic injuries?  yes  no  
If yes, please list: \_\_\_\_\_

Please indicate any of the following that apply to you.

- |  |   |
|--|---|
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Fibromyalgia       |
| <input type="checkbox"/> Headaches/Migraines     | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Heart Attack       |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Joint Replacement(s)    | <input type="checkbox"/> Blood Clots        |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Numbness           |
| <input type="checkbox"/> Neuropathy              | <input type="checkbox"/> Sprains or Strains |

Explain any conditions you have marked above:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Massage Information

Have you had a professional massage before?  yes  no

What type of massage are you seeking?  
 Relaxation  Therapeutic/Deep Tissue  
Other \_\_\_\_\_

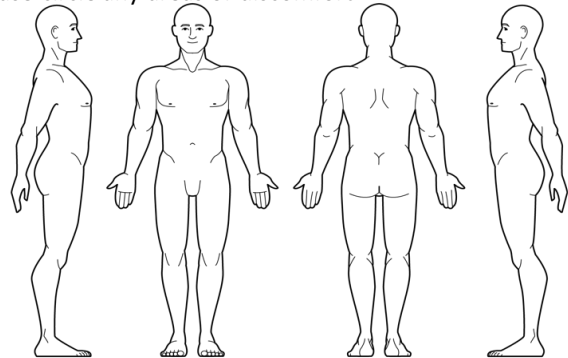
What pressure do you prefer?  
 Light  Medium  Deep

Do you have any allergies or sensitivities?  yes  no  
Please explain \_\_\_\_\_

Are there any areas (feet, face, abdomen, etc.) you do not want massaged?  yes  no  
Please explain \_\_\_\_\_

What are your goals for this treatment session?  
\_\_\_\_\_

Please circle any areas of discomfort



*By signing below, you agree to the following.*

*I have read and understand the Massage Therapy Policies and Procedures. I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.*

Client Signature \_\_\_\_\_

Date \_\_\_\_\_



## **Patti and Allan Herbert Wellness Center Massage Therapy Policies and Procedure**

### **ILLNESS POLICY & COVID-19 SAFETY**

For the safety of our members and guests, the policies have been amended to help prevent the spread of COVID-19. All changes related to COVID-19 are based on recommendations by the U.S. Centers for Disease Control and Prevention (CDC) and the University of Miami.

If you are currently experiencing any respiratory, cold, or flu-like symptoms including fever, chills, nasal drainage/congestion, sore throat, cough, muscle aches, or shortness of breath, you are required to reschedule your appointment. Any member or guest exhibiting COVID-19 as defined by the CDC will be asked to leave immediately.

Due to COVID-19 safety standards, a mask must be worn at all times while in communal areas of the facility. Clients will be instructed when they can remove their masks prior to the massage session. For the safety of our staff, all therapists will be wearing gloves for the duration of the massage.

### **SCHEDULING**

Services are scheduled by appointment only. Services can be scheduled by calling the Sales Office at 305-284-5433.

### **CANCELLATION POLICY**

24-hour notice is required to cancel or reschedule an appointment. A no-show or failure to cancel appointments at least 24 hours in advance will result in a full charge of the scheduled appointment.

*If you need to reschedule because you are not feeling well or have any COVID-19 related symptoms, please contact the Sales Office at 305-284-5433 as soon as possible. No fees will be charged for cancellations due to illness.*

### **PAYMENT**

Full payment is due when booking an appointment. Clients may purchase single sessions or a package of 8 sessions. All sessions expire 6 months after the purchase date. We only accept credit cards at this time (Visa, Master Card, Discover, or American Express).

### **REFUNDS**

Please email [wellnesssuite@miami.edu](mailto:wellnesssuite@miami.edu) for refund inquires or requests.

### **ARRIVING LATE**

If you are late for your session, we may be unable to extend your session beyond your original appointment time. You will receive the remaining time left in your appointment slot. Regardless of the length of the service received, you will be responsible for payment of the full service you scheduled.

### **GIFT A MESSAGE**

Sessions or packages can be purchased on the behalf of another member or guest by calling the Sales Office at 305-284-5433. A credit will be added to the member or guest's account. We do not provide physical gift cards.

### **GRATUITIES**

Gratuities are not included in the price of massage therapy sessions. All gratuities are at the client's discretion and can be made directly to the massage therapist or in the Sales Office.

### **HEALTH CONSIDERATIONS**

Please inform us at the time of scheduling of any health conditions, allergies, special needs, or concerns you have. Some services may not be appropriate for certain conditions.

### **COMMUNICATE YOUR PREFERENCES**

All aspects of your massage therapy session can be modified to your preference: pressure (too light or too deep), lighting in the room, style of music, temperature, and whether you prefer to have a conversation or enjoy the session in silence.