Massage Intake Form

ReNu Medical & Spa

Personal Information

Name
_____ Phone _____ (evening) _____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____Relationship _____ Phone _____

How did you hear about us? _____

Medical Information

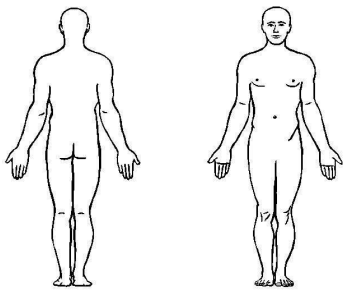
Are you taking any medications? ☐ yes ☐ no
If yes, please list name and use: _____
_____
Are you currently pregnant? ☐ yes ☐ no
If yes, how far along? _____
Any high risk factors? _____
Do you suffer from chronic pain? ☐ yes ☐ no
If yes, please explain. _____
What makes it better? _____
What makes it worse? _____
Have you had any orthopedic injuries? ☐ yes ☐ no
If yes, please list: _____
Please indicate any of the following that apply to you.

☐ Cancer	☐ Fibromyalgia
☐ Headaches/Migraines	☐ Stroke
☐ Arthritis	☐ Heart Attack
☐ Diabetes	☐ Kidney Dysfunction
☐ Joint Replacement (s)	☐ Blood Clots
☐ High/Low Blood Pressure	☐ Numbness
☐ Neuropathy	☐ 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 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 _____
Therapist Signature _____ Date _____

2425 Bradshaw Way, Pittsburg, KS 66762 Ph: 620-308-6123 Fax: 620-308-6264

ReNu Medical & Spa

CANCELLATION AND NO-SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than 24-hour notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24-hour notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24-hour notification may be subject to a **$50.00 Cancellation Fee**.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered a **NO SHOW**. Patients who No-show two (2) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments. Patients may also be subject to a **$50.00 fee for office appointment No Show Fee**.

The Cancellation and No-Show fee are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that Special unavoidable circumstances may cause you to cancel with 24 hours. Fees in this instance may be waived but **Only with Management Approval**.

For **Spa services** we ask that all clients provide a credit card to put in a secure file for our cancellation and no-show policy. We ask that you cancel your appointment at least 24 hours in advance. If you do not cancel in advance, you will be charged **50% of your service price** for missing your appointment with your on-file credit card. You will be allowed to reschedule ONCE without any additional charge. If you reschedule a second time, you will be charged **100% of your booked service price**. Late policy: If you are 10 or more minutes late, we may ask you to reschedule your appointment so it will not affect our punctual clients. If we are unable to take you at the time you arrive, you will be charged for **50% of the service** you missed.

Our Practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the Billing Department at 620-308-6123.

Please sign that you have read, understand and agree to this Cancellation and No-Show Policy.

Print Name: _____ **Date of Birth:** _____

Signature of Patient or Guardian: _____ **Date:** _____

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