OUR CORE VALUES

Customer-Focused
We anticipate, listen and deliver with precision.

Communication
We foster good communication – it builds trust and a happy environment

Balance
Brings equilibrium to all areas of our lives

Integrity
To do what is right when no one is watching

Health
To live happily!

OUR MISSION IS:

To work with integrity

Living a balanced life and serve the needs

Of our diverse community for better

Health and relaxation

Prenatal and Postpartum Massage Therapy Intake Form

Name____
Address________________________________**City**_________________**State**_____**Zip**_______
Phone (cell)___________________**E-mail** ____
Occupation ____________________ **Date of Birth**______/______/___________
Emergency Contact _________________**Relation** ___________**Phone**_________________

How did you hear about us?____
Are you currently under a physician's care?_______________________________________

To insure your satisfaction, please describe your expectations for today's visit (Please specify specific body areas needing attention):

List current medications:

List any surgeries, broken bones, or major car accidents:

Do you currently have any of the following?
_____**Heart Condition**
_____**Diabetes**
_____**Allergies:** ____
_____**Depression or anxiety**
_____**Skin Conditions (describe):** ____
_____**Recurring Headaches**
_____**Swelling in legs, hands, or feet**
_____**High/ Low Blood Pressure**

Do you exercise? (Include frequency) ____
Is this your first prenatal/postpartum massage? ___________________________________
Do you have a history of phlebitis(inflammation or swelling of a vein)? ________________

Do you have a history of deep vein thrombosis?_____________________________________

Have you been asked to self isolation or quarantine by a doctor or a local public health official in the last 14 days? ____

Have you experienced any cold or flu-like symptoms in the last 14 days (fever, cough, shortness of breath or other respiratory problem)? ___________________________________

Have you had close contact with or cared for someone diagnosed with COVID-19, or someone exhibiting cold or flu like symptoms within the last 14 days? _________________

Have you been tested for COVID-19? When were you tested? What was the result?

____

Anything else you feel we should know?

Please check any of the following that you have experienced prenatal or postpartum:
_____Acid Indigestion
_____Varicosities/Hemorrhoids
_____Sciatica
_____Anxiety
_____Incontinence
_____Round or Broad Ligament Pain
_____Nausea and/or vomiting
_____Constipation/diarrhea
_____Shortness of breath or Fatigue
_____Cesarean Scaring
_____Swelling
_____Birth Trauma
_____Muscle cramps
_____Trouble sleeping
_____Diastasis Recti
_____Mastitis/Engorgement/Plugged duct
_____Prolapse
_____Vaginal/Perineal Tear
_____Other, please explain____

This agreement releases Just For You Bodywork & Massage and or its Affiliates from ALL liabilities related to injuries that may occur during the massage. By signing this agreement, I agree to hold Just For You Bodywork & Massage or its affiliates entirely free from liability, including financial responsibility for injuries incurred during the massage session.

Just For You Bodywork and Massage 24 Hours Cancelation Policy:
24 hours advance notice is required when canceling or rescheduling your appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give 24 hours notice you will be responsible for paying the full amount of your appointment fee.

Signature ____**Date** _________________

Please read and sign our Client/ Therapist Agreement:
I realize massage is primarily for relaxation/stress relief. I am aware that this is a non-sexual massage, any misconduct will result in the termination of the massage with full payment due. I understand that any information offered by the therapist is for educational purposes only, and in no manner should be construed as a diagnosis of any kind. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. If I experience any pain or discomfort, I will immediately inform the therapist so the pressure or methods can be adjusted to my comfort level. Because massage should not be performed under certain circumstances, I agree to notify the therapist in writing of any changes in the medical information I have provided today.

Signature ____**Date** _________________

COVID-19:
I understand that close contact with people increases the risk of infection from Covid-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage from this practitioner. I also understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

Signature ____**Date**________________