 U-Knead-A Massage

796 Crestview Circle NW, Port Charlotte FL 33948

(941)255-8526 (UKAM)

[U-Knead-AMassage@comcast.net](mailto:U-Knead-AMassage@comcast.net)

Name Date

Address City State Zip

Phone (C) (H) (W)

*Please circle the number you prefer to be contacted by regarding appointments*

Email *(To be used for appointment reminders and discounts only)*

Occupation Hobbies

Referred By: Internet Sign Gift Certificate Coupon UKAM Client

Newspaper Yellow Pages Other

D/O/B \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(mm/dd/yyyy) Height\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_

Male\_\_\_\_\_\_ Female\_\_\_\_\_\_ Would Rather Not Say\_\_\_\_\_\_

**Emergency Contact**:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a professional massage before? Yes No If yes, then when?

What would you like to achieve with today's visit? Relaxation Health maintenance Pain Relief

Are you presently being treated by a Physician or other Medical Professional? Yes No If yes, please list name

Reason for treatment

**Are you allergic** to any oils, lotions or scents? Yes No \_\_\_If yes, which ones?

Any other allergies:

**Are there any factors in your life** (physical, mental, emotional) **the therapist should be aware of?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PLEASE CHECK ALL THAT APPLY TO YOU:**

\_\_Arthritis \_\_Diverticulitis \_\_Pregnancy

\_\_Auto-immune condition \_\_Fibromyalgia \_\_Scoliosis

\_\_Diabetes \_\_Headaches, migraines \_\_Seizures

\_\_Back problems \_\_Heart conditions \_\_Stress

\_\_Blood clots/Varicose veins \_\_Hepatitis A, B, C OTHER \_\_Stroke

\_\_Broken/dislocated bones \_\_High / low blood pressure \_\_Surgery

\_\_Cancer \_\_Insomnia \_\_TMJ disorder

\_\_Chemical dependencies \_\_Whiplash \_\_Skin rash/warts

\_\_Chronic pain \_\_ Muscle strain, sprain \_\_Bruises \_\_Depression, anxiety, panic \_\_ Neuropathy \_\_Anything else not mentioned

disorders, other psych cond.

**Please list current Medications or provide a list to be copied:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DO YOU HAVE ANY OF THE FOLLOWING TODAY:**

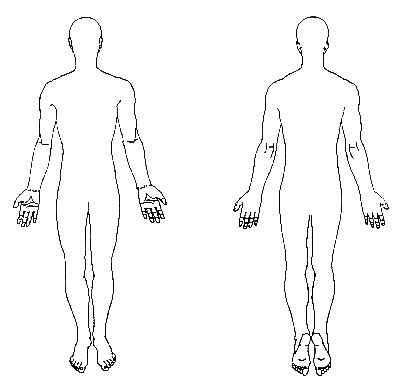
-*RASH -COLD/FLU -OPEN CUTS -SEVERE PAIN*

*-ANYTHING CONTAGIOUS - INJURIES -BRUISES -RECENT INJECTIONS IN LAST 48 HOURS*

**IF YOU ARE CURRENTLY EXPERIENCING PAIN, PLEASE INDICATE WHICH APPLY TO YOU:**

-*SHARP - DULL -THROBBING - INTERMITTENT -CONSTANT*

*-WORSE IN THE MORNING -WORSE DURING DAY -WORSE AT NIGHT*

 **Circle areas of pain or tension below**

**Front Back**

*If you would like to customize your treatment, please fill out the information below (OPTIONAL)*

**Are there any areas you would prefer NOT to have worked on?** (Face, feet, knees, etc.)

Would you prefer?

**Light Medium Deep Pressure**

Would you prefer:

**Oils/lotion scented with aroma therapy No scent at all**

Would you like Hot Packs used in your treatment?

**Yes No**

Would you like stretching or range of motion incorporated into your massage?

**Yes No**

After your massage, it's your goal to feel:

**Calm and Relaxed Revived and Refreshed**

**If you would like to add hot stones cold stones or cupping to your session please ask your therapist.**

**Necessary Disclaimer**

All of our Massage Therapists are licensed by the State of Florida. They have met all of the stringent requirements as stated by the Department of Health. They have the highest educational standards in the industry. Our treatments are therapeutic, professional and follow the professional code of ethics. At no time should they be confused with services of a sensual or sexual nature. It is at the therapist’s discretion to discontinue treatment at any point if they feel that is what your intention is.

Signature: Date:

**Client Responsibilities**

Thank you for choosing U-Knead-A Massage. Please take a moment to review our policies below. Please sign and date at the bottom to confirm that you have read and understand this statement, and that the health information you have provided is correct.

## Cancellation Policy

Everyone loses when you miss an appointment...Your therapist, another client who may have wanted that appointment time, and more importantly, YOU! Please allow 24 hours notice if you need to cancel or reschedule. If you call less than 2 hours prior to your appointment, you may be subject to pay a cancellation fee of $25.

## No Call, No Show Policy

We will allow one no-call, no-show per client without charge, however we reserve the right to request a credit card to secure your next appointment. If it happens a second time, we secure the right to charge your account for the full amount of the service scheduled.

## Non-Sufficient Funds

We will gladly accept personal checks for payment, as long as you provide a valid picture ID that matches the name and address on your checks. If your bank should return your check for insufficient funds, you will be responsible for the amount of the check plus a $15 service fee.

## I have read the above and agree to the terms and conditions stated above.

## Signature Date

## U-Knead-A Massage Inc. Lic # MM180709

## 796 Crestview Circle NW, Port Charlotte, FL 33948

## 1-941-255-8526

## Please initial each statement then sign and date below:

## \_\_\_\_\_I understand that massage therapy and body work are for the purposes of stress reduction, relief from muscular tension and spasm, general relaxation, and improvement of circulation and energy flow.

## \_\_\_\_\_ I understand that the bodywork practitioner does not diagnose illness, disease, or any other physical or mental disorder. The practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations. I have been made very clear that massage therapy and bodywork are not substitutes for medical examination or diagnosis and that it is recommended that I see a medical practitioner for any physical ailment that I may have.

## \_\_\_\_\_ I understand that services offered today, and in the future are not a substitute for medical care and that any information provided by the therapist is for educational purposes only, and is not diagnostically prescriptive in nature.

## \_\_\_\_\_ I have stated all of my known medical conditions on the Client Information Form. I have consulted a medical doctor or licensed medical health care practitioner regarding any checked or described conditions.

## \_\_\_\_\_ I realize it is solely my responsibility to keep the bodywork practitioner updated on any changes in my physical health and I understand that U-Knead-A Massage Inc. and the practitioner shall not be liable should I fail to do so.

## \_\_\_\_\_ I understand that all massage therapy and bodywork offered is strictly non-sexual.

## \_\_\_\_\_ By signing this release, I hereby waive and release the U-Knead-A Massage Inc. and it’s staff, massage therapists, and bodywork practitioners from any and all liability, past, present, and future relating to massage therapy and bodywork.

## I have received the policy statement, and have read and agree to the policies therein.

## 

## Client name/signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## 