**Crystal Body Revision Massage & Ozone Therapy**

**Intake, Wellness, & Consent form**

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| **Name:** |  | **Address:** |  |
| **Email Address:** |  | **City:** |  | **State:** |  |
| **Phone (primary):** |  | **Zip Code:** |  | **Birthdate:** |  |
| **Phone (secondary):** |  | **Occupation:** |  |
| **\*Emergency Contact:** |  | **\*Emergency Contact Phone:** |  |
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| **How did you hear about us?** |  | **Preferred method of contact:** |
| [ ]  Facebook | [ ]  Google | [ ]  Yelp |  | [ ]  Phone | [ ]  Text | [ ]  Email | [ ]  Other |
| [ ]  Yahoo | [ ]  Instagram |  |  | **Have you ever had a professional massage?** |
| [ ]  Friend: |  |  | [ ]  Yes | [ ]  No |
| [ ]  Event: |  |  | **Have you ever had a deep tissue massage?** |
| [ ]  Other: |  |  | [ ]  Yes | [ ]  No |
|  |  |  |
| Welcome to your massage! Communication is key in maintaining an open, comfortable and professional massage therapy session. If you have any questions, comments or concerns please feel free to discuss them with your therapist as soon as possible.It is your responsibility to inform your therapist of any pre-existing conditions, limitations or specific sensitivities prior to your session and to inform your therapist if you feel any discomfort during your session. It is within our ability to adjust pressure or techniques to best accommodate your needs. You understand and voluntarily accept any risk associated with your massage, or from any use of the company’s facilities, and hereby release Crystal Body Revision from all liability for any injury, including, without limitation, personal, bodily, or mental injury, economic loss or any damage to you resulting therefrom. You further hereby release all the foregoing personnel and entities from all liability arising from any such injury or damage resulting from your failure to disclose any pre-existing condition, limitation or specific sensitivities, or your failure to inform your therapist of any discomfort during the session. Your therapist may determine that it is unsafe for you to proceed with or continue a therapeutic session due to health-related concerns. In this event, you may be required to provide a physician’s medical release prior to continuing treatment. The undersigned acknowledges that he/she has read this agreement: |
| **Signature:** |  | **Date:** |  |
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| **Please help us ensure a safe & comfortable massage experience by providing the following information:** |
| [ ]  Blood Clots | [ ]  Immune Deficiency | [ ]  Disc Trouble | Explain selected conditions: |
| [ ]  Cancer | [ ]  Nerve Damage | [ ]  Insomnia |  |
| [ ]  Diabetes | [ ]  Joint Replacement/Hardware | [ ]  Thyroid trouble |  |
| [ ]  Fibromyalgia/Lupus | [ ]  Infections | [ ]  Varicose Veins |  |
| [ ]  Headaches | [ ]  Pain (joint, muscle, nerve) | [ ]  Skin Condition |  |
| [ ]  Heart Problems | [ ]  Arthritis | [ ]  Anxiety/Depression |  |
| [ ]  High/Low Blood Pressure | [ ]  Osteoporosis | [ ]  Surgeries |  |
| [ ]  Stroke/Aneurysm | [ ]  Neurological Disorder | [ ]  Pregnancies |  |
| [ ]  Allergies (including foods, essential oils & chemicals) | [ ]  Other |  |
| [ ]  Medications |  |
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| **Have you experienced any of the following in the past 3 months? If yes, please explain.** |
| [ ]  Pain | [ ]  Numbness | [ ]  Tingling | [ ]  Swelling | [ ]  Fatigue | [ ]  Inhibited activities as result of current condition |
|  |
| **Select areas you are comfortable having massaged:** | **Desired pressure:** |
| [ ]  Gluteal | [ ]  Abdominal | [ ]  Pectoral | [ ]  Head/face | [ ]  Feet | [ ]  Light | [ ]  Firm | [ ]  Deep |

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| **\*\*\*Appointment Cancellation, No-Show, and Timeliness Policy\*\*\*** ***Crystal Body Revision has a 24-hour Cancellation and Rescheduling Policy.***If you miss, cancel, or change your appointment with less than a 24-hour notice, you will be charged for your full session. Payment for a missed session can be made over the phone or added to your total at your next appointment. If payment is not received after 14 days, you will be billed through the mail.* ***If cancellations less than 24 hours in advance occur more than 4 times in a 12 month time frame, Crystal Body Revision reserves the right to end your business relationship and prohibit your scheduling & provision of future services.***
* ***Timeliness to appointments is greatly appreciated. If you arrive for your scheduled appointment more than five minutes late, Crystal Body Revision reserves the right to take this time out of service provision. If this occurs, full payment for the original scheduled service will be due.***

These policies are in place out of respect for your therapist’s time and the time of his/her other clients. Cancellations with less than a 24-hour notice or failure to cancel your appointment prevents therapists from accepting appointments during that time period. Additionally, arriving late to your appointment can cut into the service time of clients who are scheduled immediately after your appointment.***Please sign below to acknowledge that you have read & understand this cancellation policy, as described above. Thank you for your understanding and cooperation.*** |
| **Signature:** |  | **Date:** |  |
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| **Ozone Steam Sauna Therapy Consent**I understand that the Ozone Steam Sauna Therapy that I receive from O3ZONE Therapy Services via Crystal Body Revision is provided for the basic purposes of relaxation and relief of muscular tension and joint discomfort. I also understand that the Ozone Steam Sauna Therapy should not be construed as a substitute for any medical treatment, diagnosis, prevention, or curing of any disease. Crystal Body Revision reserves the right to refuse to perform any service on anyone for any reason. **NOTES:** * Ozone therapy may be contraindicated for some heart conditions. If you have a heart condition, we recommend consulting a physician prior to receiving Ozone therapy.
* Ozone therapy is NOT advised for pregnant mothers or anyone who has received a living organ transplant.

By checking the boxes below, you are acknowledging that you are free from these conditions.  |
| [ ]  **I am not pregnant** | [ ]  **I have not received a living organ** | [ ]  **I do not have a heart condition** |
| **Signature** |  | **Date:** |  |
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| **For office use only:** |
| **Ozone seat height:** |  | **Ozone temperature:** |  |
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