Keva Mack Massage & Wellness | Grand Prairie, TX
817-668-5382 | www.KevaMack.com | Keva@KevaMack.com

Intake Form

Name: _____ Date _____

Address: _____City: _____Zip:_____

Email: _____Phone #:_____

Date of Birth:_____ Are you under the age of 17? Please Circle: Yes or No

If yes, you must have the written consent of your parent or guardian to receive massage and wellness services.

Why are you coming in today? Please Circle: Pain Stress Other_____

Please circle all that apply: Spinal Problems Allergies High Blood Pressure Smoker

Bruise Easily Varicose Veins Heart Conditions Injuries Migraines

Currently Pregnant? Due Date:_____

Please explain any items circled above here:_____

_____

Any additional medical conditions your therapist should be made aware of? Please Circle: Yes or No

Current Medications: _____

Type of massage or wellness service you are requesting (Please circle below):

Swedish | Deep Tissue | Lymphatic | Therapeutic | V-Steam | Reiki | Coaching | Other: _____

Areas of pain/tension/concern: _____

Areas of body to be avoided: _____

I acknowledge that Massage Therapy and Wellness Services are not a substitute for medical examination or diagnosis. It is recommended that I see a physician for any physical or mental ailment that I may have. I understand that the massage therapist or wellness professional does not prescribe medical treatments or pharmaceuticals, and does not perform mental health counseling. I am aware that if I have any serious medical diagnosis I must provide a physician's written consent prior to services. Breast massage on female clients can not be performed without the written consent of the client, prior to the massage session. Draping will be used during all Massage Therapy sessions. If the client is uncomfortable for any reason during a session, they may end the session at any time.

Client Signature: _____ Date: _____
(Parent or Guardian if under age 17)

Therapist Signature: _____ Date: _____

Precautionary Coronavirus Liability Release Form

Due to the 2019-2020 outbreak of the novel Coronavirus, COVID-19, we are taking extra precautions with the intake of each client, health history review, as well as sanitation and disinfecting practices.

Please complete the following and sign below.

Symptoms of COVID-19 include:
• Fever
• Fatigue
• Dry cough
• Difficulty breathing

I, _____ agree to the following:
(Print your name here)

- I understand the above symptoms and affirm that I, as well as all household members, do not currently have, nor have experienced the symptoms listed above within the last 14 days.

- I affirm that I, as well as all household members, have not been diagnosed with COVID19 within the last 30 days.

- I affirm that I, as well as all household members, have not knowingly been exposed to anyone diagnosed with COVID-19 within the last 30 days.

- I affirm that I, as well as all household members, have not traveled outside of the country, or to any city outside of our own that is or has been considered a “hot spot” for COVID-19 infections within the last 30 days.

- I understand that this business and my massage therapist cannot be held liable for any exposure to the virus or any other contagion caused by misinformation on this form or the health history provided by each client.

By signing below I agree to each above statement and release the massage therapist or wellness professional, business, its employees and associates from any and all liability for the unintentional exposure or harm due to COVID-19.

Your massage therapist or wellness professional, employees and associates of this facility agree that they abide by these same standards and affirm the same. We also affirm that we have improved and expanded our sanitation protocols to more thoroughly fight the spread of COVID-19 and other communicable conditions.

Signature _____ Date _____

Reiki Therapy Release Form

Client's Name_____

Have you ever had a Reiki treatment? YES NO

What is your goal for having a Reiki treatment today?_____

_____

Please please put a check on the line next to the modality/tool you're comfortable with being used during your Reiki session:

___Singing Bowls/Chimes
___Essential Oils
___Pendulums
___Acupressure
___Guided Imagery/Relaxation
___Energy Readings
___Breathwork
___Crystal Therapy
___Rattles/Frame Drums
___Tuning Forks
___Chakra Balancing
___Aura Cleansing
___Meridian Tapping

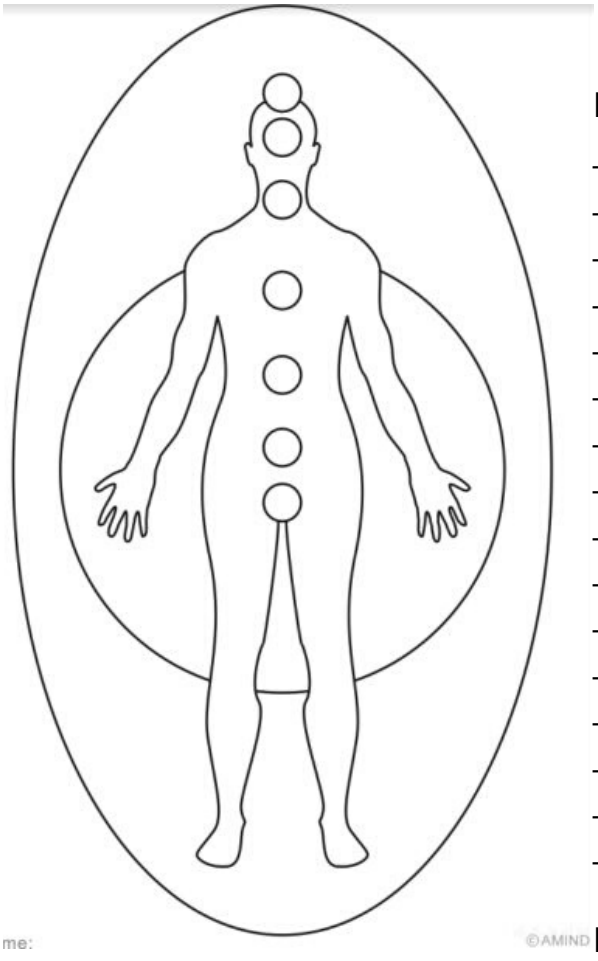
I understand that the Reiki I receive is provided for the basic purpose of relaxation and relief of tension and stress. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that adjustments can be made for my level of comfort. I understand that I can request the session be stopped for any reason, at any time. I further understand that Reiki should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician or other qualified medical specialist for any physical or mental ailment that I am aware of. I understand that Reiki Therapists are not qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of Client _____ Date _____

Signature of Reiki Therapist _____ Date _____

Signature of parent if client is under the age of 18 _____

Client's Name: _____



Date:_____ Receipt #:_____

LMT Signature:

_____

Date:_____ Receipt #:_____

LMT Signature:

_____