saratoga holistic massage

BioMat Intake

Name: _____

E-mail: _____

Cell Phone: _____ Home Phone: _____

DOB: _____ Occupation: _____

Please check the boxes below to confirm you DO NOT have any of the following conditions. The BioMat is contraindicated if any of the following conditions are present.

I *DO NOT* have:

___ Organ Transplants
___ Fever
___ Cognitive Disability
___ Skin Conditions
___ Acute Disease
___ Acute Tumor
___ Visually Impared Conditions
___ Heart Conditions

Please consult with your physician or use the BioMat on very low heat if any of the following conditions are present:

___ Immobility
___ Internal/External Pacemaker
___ Defribillator
___ Adrenal Insufficiency
___ Systemic Lupus
___ Erythematosus
___ Multiple Sclerosis (MS)
___ Autoimmune Disorders
___ Bypass Surgery
___ Diabetes
___ Hypertension (High Blood Pressure)
___ Joint Injuries
___ Heat Insensitivity
___ Pregnancy
___ Recent Radiation/Chemotherapy
___ Surgical Implants
___ Silicone Implants

Please read and sign to acknowledge: I have stated all of my known medical conditions on this intake form and I have consulted a licensed medical health care practitioner regarding these conditions. It is my responsibility to make my practitioner aware of any change(s) in my health status. I understand these services are a complimentary aid to my well-being and are not substitutes for medical care. Therefore, I release and discharge Saratoga Springs Massage Therapy LLC from any and all claims or causes of action arising out of or relating to these services. Any information provided to you by the practitioner is for educational purposes only and is not diagnostic. Either party reserves the right to end a session at any time.

Client Signature: _____ Date: _____