The Healing ZONE **CONFIDENTIAL INTAKE** **Date: ______________**

PLEASE PRINT (clearly)

Name:____ Pronouns: They/them She/her He/him

Address:____

City:________________________________ State:__________________ Zip_________________

Cell Phone:_________________________ Use TXT? No Yes UMASS employee ID: ___________

E-mail:_____________________________________ Date of Birth:__________________________

How did you hear about The Healing ZONE? Internet, Facebook, Event, Friend: ________________________
Have you had Massage Therapy before? Yes ( ) No ( ) When? _____________________
Please list any **medications** you take regularly:____
Are you involved in a regular exercise/ how often?____
What is your activity level? _________________________________
Do you have any medically related **restrictions?** No ____ Yes____ Position restrictions?
Please explain____

DO YOU HAVE ANY OF THE FOLLOWING? IF SO, PLEASE CHECK BOX to the LEFT:

	Allergies (nuts, scents)		**COVID-19** or Long **COVID**		**Lymphedema** Risk or History
	Anxiety		Depression		Neuropathy
	Arthritis		Diabetes (injection site)		**Osteoporosis** fragile bones
	Asthma		Dizziness		Pacemaker / Port
	Blood clots / History of DVT		Epilepsy		Pins or plates
	Blood Pressure: ( )High ( ) Low		Headaches/how often?		**Pregnancy** _____ week Due date
	Bruising tendency		Heart disease		Sensitive Skin
	Cancer-Type: **Active treatment**		Hemophilia		Swelling /Where?
	Cancer-personal history **Type: When:**		Hernia		Varicose veins

Have you been vaccinated? Date: ________________

- ❑ One Dose (Pfizer or Moderna)
- ❑ Both Doses (Pfizer or Moderna) - 2 weeks past 2nd shot
- ❑ Janssen Single Dose - 2 weeks past
- ❑ Not Vaccinated
- ❑ Boosted DATE : __________________

Have you ever been diagnosed with COVID-19 (positive fcr or antigen test), received a presumed COVID-19 diagnosis or tested positive for COVID-19 antibodies?

❏ yes ❏ no

Describe any lingering effects:____

Do you have any NEW challenges with exercise or getting your heart rate and respiratory rate up?

❏ yes ❏ no

Have you had a NEW onset of unexplained muscle aches and pain since the emergence of the virus? *

❏ yes ❏ no

Have you seen any NEW or unexplained marks, rashes, spots, bumps, or other lesions on your skin, fingers or toes?

❏ yes ❏ no

PLEASE NOTE: CANCELLATION POLICY ½ FEE FOR CANCELLATION WITHIN 24-HOUR and FULL FEE SAME DAY CANCELLATION. DUE TO COVID-19, ILLNESS RELATED CANCELLATIONS WILL NOT BE CHARGED ANY FEES. **STAY WELL!**

Please read and sign to indicate your content to receive massage at The Healing Zone:

It is my choice to receive massage or bodywork. I realize the treatment being given is for the purpose of stress reduction, relief from muscle tension, spasm or pain. I understand that therapists do not diagnose illness or prescribe medical treatment. I am responsible for consulting a PCP for any ailments I may have. I have stated all medical conditions and medications.

I understand that because massage involves touch and close physical proximity over an extended period of time there may be an elevated risk of disease transmission, including COVID-19. The therapist has explained the risks to me and I consent to receive a massage. I also consent to having my contact information shared with the relevant government authorities in the event that contact tracing is required.

Signature:______________________________ Date:______________________

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