In order to submit this form, you should open it with Adobe Acrobat Reader.

Max Reset Intake & Consent

Please complete this intake form before your Max Reset session at Maximus Health and Fitness. All information is kept confidential.

Full Name *

First Last

Phone Number *

Please enter a valid phone number.

Are you a member of Maximus? *

- Yes
- No

Which service are you requesting today? *

- Deep Tissue Release
- Quick Reset Recovery
- Sports Recovery
- Stretch and Mobility
- Total Body Reset
- Cupping

Which areas would you like to focus on? *

- Neck / Shoulder
- Upper Back
- Lower Back
- Hips / Glutes
- Legs / Hamstrings
- Arms / Forearms

Are you currently experiencing any of the following? *

- Muscle soreness
- Tight muscles
- Recent injury
- Chronic pain
- Broken skin or open wounds
- Active skin infection or rash
- Blood thinners or anticoagulant use
- Bleeding disorder
- Varicose veins
- Cancer or undergoing chemotherapy
- Implanted medical device over the area
- Diabetes with poor circulation
- Recent surgery
- None of the above

Other *

Do you have any allergies to oils, lotions, or scents? *

- Yes

No

Are you currently pregnant? *

☐ No ☐ Yes

If Yes, How many weeks pregnant? *

For safety, massage will be postponed during the first trimester. Doctor approval may be required.

Feeling sick (fever, cough, flu-like symptoms)? *

☐ No ☐ Yes

Please review and confirm: *

- ☐ I understand massage/bodywork is provided for wellness and recovery purposes only and is not a substitute for medical care.
- ☐ I understand payment is due immediately after the session.
- ☐ I understand inappropriate behavior will not be tolerated, and the session may be ended immediately with full payment due.
- ☐ I understand services may be refused at the therapist's discretion.
- ☐ I understand massage/bodywork may include pressure, stretching, and mobility techniques, and I will communicate any discomfort during the session.
- ☐ I understand that cupping therapy may be offered as part of my session or as an add-on and may leave temporary circular marks or bruising on the skin.
- ☐ I understand that I am responsible for informing the therapist of any medical conditions, injuries, medications, or skin sensitivities that may affect my massage or cupping session.
- ☐ I consent to receive massage/bodywork during this session.

Signature

Date *

Month Day Year