

PATIENT INFORMATION

Patient Legal Name: _____ Prefers to be called: _____ Today's Date: ___/___/___

Birth Date: ___/___/___ Age: _____ Gender: F M

How did you learn about us? _____ If you were referred, by whom? _____

If you are under 18 years of age, who are your legal parents or guardian?

Parent/Legal Guardian: _____ Relationship: _____

Phone (____) _____ Date of Birth: _____

Who do you normally live with? Mother and Father Father Mother Legal Guardian None of these

Address _____ City _____ State _____ Zip _____

Phone number where we can leave a message: (____) _____ Email _____

Name of Spouse _____ Spouse's Date of Birth ___/___/___

Who should we contact in the event of an emergency? _____ Phone (____) _____

How would you rate your general health? Excellent Good Fair Poor

Have you had a professional massage before? Yes (Date of last treatment) _____ No

List current medications and the conditions they are treating: _____

Please tell us about any allergies or hypersensitivities: _____

List any major accidents or surgeries (including dates): _____

Reason for initial massage: _____

Head/Neck

Headaches/Migraines Vertigo/Dizziness Ringing in Ears Hearing Loss Vision Problems

Respiratory

Asthma Shortness of Breath Chronic Cough Bronchitis Emphysema Sinusitis
 Frequent Colds Smoker History of Respiratory Difficulties

Nervous System

Sensor Loss/Change Sciatica Seizures Numbness/Tingling Epilepsy Multiple Sclerosis

Musculoskeletal System

Arthritis Osteoporosis Bursitis Pins/Plates/Wires/Artificial Joint Family History of Arthritis
 Tendonitis Jaw Pain (TMJ)

Reproductive

Pregnant Gynecological Problems Given Birth

Cardiovascular

High Blood Pressure Heart Attack Heart Disease Phlebitis/Varicose Veins Hemophilia
 Chronic Congestive Heart Failure Low Blood Pressure Stroke Poor Circulation
 Pacemaker Family History of Cardiovascular Problems

Skin & Infections

- Hepatitis Herpes Lyme Disease HIV/AIDS Tuberculosis Infectious skin conditions

Other Conditions

- Cancer Unexplained Weight Loss Fibromyalgia Depression Psychiatric Disorder
 Diabetes Digestive Conditions Chronic fatigue syndrome Anxiety
 Other _____
-
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Disclaimer

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Treatments will not be covered by insurance, and I understand that it is my responsibility to pay for professional services when rendered.

It is our policy that payment be made at the time of each visit unless alternate payment arrangements are made.

Missed Appointment & Late Arrivals

We ask for patients to arrive at least 10 minutes before their scheduled appointment time, especially if paperwork still needs to be completed. Up to 5 minutes will be taken out of a 30-minute massage and up to 15 minutes will be taken out of the scheduled 60- or 90-minute massage if late. After the set time limitations, we will need to reschedule the appointment and will charge half the amount for the service expected to be rendered.

We require at least 48 hours' notice of a cancellation or change in appointment.

For appointments canceled past the 48-hour notice, a fee of half the amount of the service expected to be rendered will be charged to the credit card on file. For missed appointments with no notice, the full fee of the expected service will be charged to the credit card on file.

Having said this, we understand that emergencies sometimes occur. If there is a legitimate emergency that prevents you from keeping your appointment, please let us know and we will gladly waive this fee.

Patient Signature: _____ Date: ____/____/____

(If patient is a minor, consent must be signed by parent or official guardian)

Parent Guardian or Legal Representative (Print Name): _____

Parent Guardian or Legal Representative Signature: _____ Date: ____/____/____

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