A Therapeutic Effect

Personal Data

Patient's Name: ______________________ **Today's Date:** ______________________

Address: ______________________ **Phone Number:** preferred ______________________ OK to leave message? **Y or N**

______________________ other ______________________ **Y or N**

** Please indicate best number for us to call should we need to cancel an appointment due to weather, illness, or other emergency **

email: ______________________

How should we confirm your appointments? **Phone Call** or **Automated Email** (please circle one)

Date of Birth: ______ / ______ / ______ (month / day / year)

Sex: Male ☐ Female ☐ Transgender ☐

Occupation: ______________________ **Referred by:** ______________________

Emergency Contact: ______________________ **Phone Number:** preferred ______________________ OK to leave message? **Y or N**

Relationship: ______________________ other ______________________ **Y or N**

Are you currently under a Physician's care? Yes No

If yes, please explain: ______________________

Please list and date any past or present injuries, accidents, or medical treatment including surgeries:

____

____

Are you pregnant? Yes No ***If yes, some services may not be administered.***

Please list all known allergies: ______________________

Please list all medications and supplements you are taking: ______________________

____

CANCELLATION POLICY

If you are unable to keep your appointment - for any reason - please give us as much notice as possible. For appointments broken with less than 24 hours notice, we reserve the right to charge 50% of the standard fee. Appointments that "no show" will be charged in full to cover the therapist's time.

Massage New Client Information

Client Name:______________________

Have you previously had a massage? ☐ **No** ☐ **Yes** **How often?** ______________________

Present Symptoms (What is your major complaint or what would you like to improve?):

____

____

How long have you had this condition? ______________________

Do you have any of the following conditions? (Please CIRCLE all that apply)

Neck / Spine Injury	Back Pain	Sciatic / Leg Pain	Sports Injuries
Headaches	Arthritis	Varicose Veins	PMS / Painful Menstruation
Depression	Anxiety	High Blood Pressure	Skin Disorder
Diabetes	Fibromyalgia	Allergies	HIV Positive
Cancer	Easy Bruising	Acute Pain	Other Infectious Disease
Pregnant or Trying to Become Pregnant		Other (Please Explain):	______________

If you are pregnant or trying to become pregnant <u>and have previously miscarried</u>, massage is contraindicated in the <u>first trimester</u>.

Do you wear ☐ contact lenses ☐ hearing aids, or ☐ dentures?

I have read the above information and discussed it with my Massage Therapist. I understand Massage Therapy does not replace medical treatment or medications. It is a form of health and wellness maintenance utilizing techniques of traditional therapeutic body work. I agree to update my Massage Therapist of any changes in my health or any conditions I may have. I am aware that the Massage Therapist does not diagnose disease, prescribe medication, or manipulate bones.

Signature: ______________________________ **Date:** ______________