Massage Client History

DATE _____

CLIENT NAME _____ REFERRED BY _____

MAILING ADDRESS _____ CITY _____ ZIP _____

STREET ADDRESS _____ CITY _____ ZIP _____

HOME PHONE ( )_____ WORK PHONE ( )_____ EXT _____

CELL PHONE ( )_____ E-MAIL _____

BIRTHDATE _____ GENDER (M/F/O) _____

MARITAL STATUS (M/S/D/W/O) _____ CHILDREN _____

OCCUPATION/EMPLOYER OR STUDENT/SCHOOL _____

BUSINESS ADDRESS _____

NAME OF YOUR MEDICAL DOCTOR_____

Please circle Yes or No to the following questions:

Are you under Chiropractic care? Y/N

Have you had a previous massage? Y/N

Do you frequently suffer from stress? Y/N

Do you experience frequent headaches? Y/N

Do you have high blood pressure? Y/N

Do you have epilepsy or seizures? Y/N

Do you have any contagious diseases? Y/N

Do you have cardiac or circulatory issues? Y/N

Do you have Diabetes? Y/N

Do you nave numbness? Y/N

Do you have arthritis or chronic back pain? Y/N

Are you pregnant? Y/N

Do you have varicose veins? Y/N

Do you have Osteoporosis? Y/N

Do you have any allergies? Y/N

Do you bruise easily? Y/N

Physical, Emotional, Mental challenges you would like to address:

_____

_____

_____

History of accidents, injuries, operations (please give the year each occurred):

_____

_____

_____

Are you taking any medications or drugs? Please list them below:

_____

_____

Do you have any other medical conditions? Y/N (If YES, please list)

_____

_____

ACKNOWLEDGMENT AND CONSENT TO RECEIVE SERVICES

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. I have read, and/or discussed, with the massage therapist, the nature and risks of massage. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and or stroke may be adjusted to my level of comfort.

I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I am responsible to see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the massage therapist and staff updated as to any changes in my medical profile and understand that they are not to be held liable should I fail to do so.

I understand that each practitioner at "Presence" is independent and that my care with one does not imply a relationship with any other practitioner. In the event that I seek care from more than one practitioner at "Presence," I give consent to allow those practitioners to communicate and share information about me.

I consent to use the services offered by the massage therapist and agree to be personally responsible for payment of my session. I agree to call within 24 hours if I need to cancel or reschedule an appointment or will pay for the missed appointment.

CANCELLATION POLICY

You may cancel your appointment without charge up to 24 hours preceding your appointment. If you do not show up for your scheduled appointment, or cancel on the day of your appointment, you will be charged 50% of the charge for your scheduled appointment.

Please leave your credit card number on file with our office. We will not process the charge on until the time of the appointment.

LATE ARRIVAL POLICY

Please arrive at least ten minutes before your scheduled appointment time in order to ensure a full session. If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for the "full" session.

By signing below, I state that I have read and understand the above agreements and policies, and I consent to their terms and to receive massage at "Presence."

Client or Guardian Signature _____ **Date** _____