MASSAGE THERAPY

PATIENT INFORMATION DATE______________

NAME______________________________**DOB**____________________**AGE**__________

ADDRESS______________________________CITY/STATE____________________ZIP__________

OCCUPATION__________________________

EMAIL ADDRESS__________________________

CAN WE ADD YOU TO OUR EMAIL/MAILING LIST? Y N

PHONE (H)______________________________**(C)**______________________________

Cell Phone Carrier ____

PATIENT COMPLAINT

PRIMARY COMPLAINT____

WHEN DID IT START?____

WHAT MAKES IT WORSE?____

WHAT MAKES IT BETTER?____

HAVE YOU SEEN A PHYSICIAN? YES________NO__________

HAVE YOU EVER RECEIVED TRIGGER POINT INJECTIONS? YES______NO______

LIST ANY MEDICATIONS AND PURPOSE____

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ARE YOU PREGNANT? YES__________NO__________IF YES DUE DATE?________________

HAVE YOU HAD MASSAGE THERAPY BEFORE? YES____________NO__________

LIST ANY CONCERNS AND PROBLEM AREAS YOU MAY HAVE________________________________

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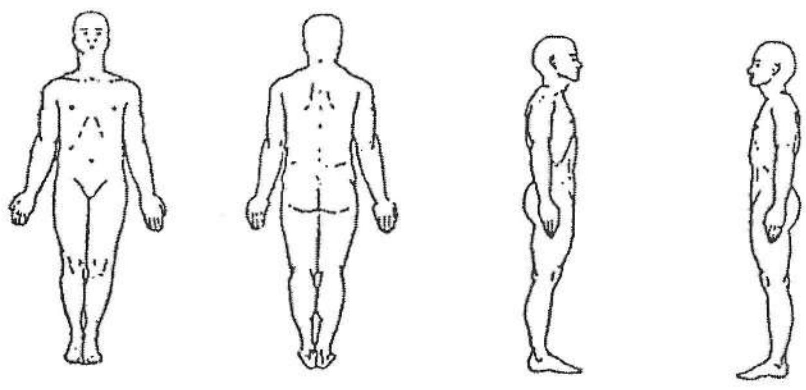
PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS IF YOU HAVE HAD THEM RECENTLY

- ○ Allergies
- ○ Sinusitis
- ○ Bursitis
- ○ Diabetes
- ○ Varicose Veins
- ○ Blood Dots
- ○ Heart Condition
- ○ Severe Depression
- ○ Cancer
- ○ Chest Pain
- ○ Shortness of Breath
- ○ High blood pressure
- ○ PMS
- ○ Fatigue
- ○ Dizziness
- ○ Ringing in Ears
- ○ Loss of Balance
- ○ Fainting Spells
- ○ Headaches
- ○ TMJ Dysfunction
- ○ Neck Pain
- ○ Shoulder Pain
- ○ Back Pain
- ○ Lower Back Pain
- ○ Herniated Disks
- ○ Low blood pressure
- ○ Insomnia
- ○ Cold Feet
- ○ Cold Hands
- ○ Numbness of hands
- ○ Edema
- ○ Skin Disorders
- ○ Hepatitis
- ○ Constipation
- ○ HIV
- ○ Abdominal Hernia
- ○ Stomach Disorders
- ○ Spinal Bifida
- ○ Sciatica

PLEASE INDICATE AREAS OF DISCOMFORT, ESPECIALLY MUSCLE TIGHTNESS



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Because a massage therapist must be aware of any existing physical conditions that I may have, I have listed known medical conditions and physical limitations and I will inform my massage therapist of any changes in physical health. I understand and agree that: (1) the massage therapy that I am given is for the purpose of stress reduction from muscular tension or spasm and/or for improving circulation: (2) a massage therapist can neither diagnose illness, disease, or any other medical, physical, or mental disorder, nor performs any spinal manipulations: (3) I am responsible for consulting a qualified physician for any physical ailments I may have.

I agree that all services rendered me are charged directly to me and I am responsible for payment unless arrangements have been made. I agree to pay for all scheduled appointments that I am unable to keep and will notify the office at least 24 hours in advance.

SIGNATURE____ DATE________________

Massage Therapy Appointment Policy

Failure to cancel or reschedule appointments appropriately, not only affects the massage therapist, but also other patients who may have been in need of that time. We ask that you please be respectful of your time and ours.

I, the client/patient, agree:

To Be On Time: ______________Initials

- To receive massage therapy services, on time, for every appointment.
- I am responsible for my appointments and any consequences associated with failing to keep or be on time for appointments.

To Give At Least **24 Hour Notice**: ______________Initials

- PHONE the office at (631)675-2910 at least 24 hours in advance of any appointment I need to miss, cancel, or reschedule.

To Forfeiture: ______________Initials

- If the first appointment is missed, cancelled, or rescheduled without **24 hour notice** there will be a **$25 missed appointment fee.**
- If the second and/or future appointment(s) are missed, cancelled, or rescheduled without **24 hour notice**: There will be a **$50 missed appointment fee.** If the session was part of a pre-pay program, that session may be lost, without reimbursement.
- If any appointment(s) for which the Client/Patient is more than 15 minutes late. If there is no appointment for that Client/Patient, there will be a **$50 missed appointment fee.** If the session was part of a pre-pay program, that session may be lost, without reimbursement, if the Client/Patient is less than 15 minutes late, then the Client/Patient will receive **ONLY** the remaining minutes of the massage.

I, THE CLIENT/PATIENT have read and understand the above agreement completely and agree to comply fully with collections of any fee that I owe.

I, THE CLIENT/PATIENT will need to pay for any fees prior to receiving future massages.

______________________________ ______________
Printed Name Date

______________________________ ______________
Signature Date

Credit Card # ______________________ Expiration Date__________ CCV Code__________