
**NAME:**_____ **EMAIL:**_____

**ADDRESS:**_____**CITY:**_____**ZIP CODE:**_____

**CELL PHONE:**_____**HOME/WORK PHONE:**_____**BIRTH DATE:**_____

**EMPLOYED BY:**_____ **HEALTH INSURANCE:** _____

**REFERRED BY:** (Friend) (Relative) (Newspaper Ad) (Yellow Pages) (Sign) (Mail) (Other:_____)

**WHICH ONE OF OUR PATIENTS CAN WE THANK FOR REFERRING YOU?**_____

**PLEASE CIRCLE YOUR CURRENT SYMPTOMS:**

(Headaches) (Neck Pain) (Neck Stiffness) (Allergies) (Shoulder/Arm Pain) (Upper Back Pain)

(Mid Back Pain) (Low Back Pain) (Hip/Pelvis Pain) (Sinus Problems) (Asthma) (Stomach Pain) (Chest Pain)

(Numbness) (Arthritis) (Sciatica) (Stress) (Other):_____

**MY SYMPTOMS ARE DUE TO:** (Auto Accident) (Work Accident) (Home Accident) (Gradual Onset)

**DATE OF LAST MASSAGE:**_____**WERE YOU SATISFIED?** (No) (Yes)

**HOW OFTEN DO YOU GET MASSAGE NOW?** (1/week) (1/month) (Occasionally) (Other)_____

**HOW OFTEN WOULD YOU LIKE TO GET MASSAGE?** (1/week) (1/month) (Occasionally) (Other)_____

**WHAT IS KEEPING YOU FROM GETTING THE AMOUNT OF MASSAGE YOU WANT?** (Time) (Money) (Other)

***FEMALES: ARE YOU PREGNANT AT THIS TIME?** (No) (Yes) **DUE DATE:**_____

**Office Policies:** *If I am accepted as a patient at The Massage Club I agree to pay for all services, including services not covered by my insurance company. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account.*

**Consent To Treat:** *I also understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon my request. I now authorize Lynde Greenwald, LMT or Erin Steinhauer, LMT to proceed with any necessary treatment covered by her license. I have read The Massage Club's office policies and consent to treat information, and I agree with them by signing below:*

**SIGNATURE:**_____**DATE:**_____

**PARENT/GUARDIAN:**_____**DATE:**_____


**PATIENT'S NAME:**_____**DATE:**_____

**YES NO Have you ever experienced a professional massage/bodywork session?**

**YES NO Do you frequently suffer from stress?**

**YES NO Do you experience frequent headaches?**

**YES NO Do you experience frequent lower back pain?**

**YES NO Do you have tension or soreness in a specific area?** _____

**YES NO Would you be interested in a free consultation and exam with one of our Doctors about this problem?**

**YES NO Do you have high blood pressure?**

**YES NO Are you epileptic?**

**YES NO Are you diabetic?**

**YES NO Have you ever had surgery?**

**YES NO Have you had any broken bones in the last two years?**

**YES NO Do you have cardiac or circulatory problems?**

**YES NO Do you have numbness or stabbing pains anywhere?**

**YES NO Are you sensitive to touch/pressure in any area?**

**YES NO Do you have any other medical condition I should be aware of?**

**COMMENTS:**_____
_____
_____
_____
_____

**SIGNATURE:**_____ **DATE:**_____


****CANCELLATION POLICY****

**If you have to reschedule or cancel your appointment for any reason, that is no problem at all! We just ask that you abide by the following protocol so we can offer the greatest amount of availability to our patients!**

**You will not be charged if you cancel/reschedule before the close of business on the day preceding your appointment.**

**You will be charged 50% of the massage charge if you cancel/reschedule same day.**

**You will be charged up to the total charge of the massage if you miss your appointment without calling.**

I have read and agree to the cancellation terms and conditions by signing below:

**Signature: _____** **Date: _____**

**Office Manager Signature: _____**