

Sarah's

MASSAGE THERAPY

CLIENT INFORMATION

Please take care to fill out this form thoroughly and carefully. The information will help your massage therapist provide optimal care. Your cooperation is deeply appreciated.

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

E-mail _____

Phone: *Please check the box of the number that you prefer I use to reach you*

Home _____ Cell _____ Office _____

Age: *(required for insurance billing)* _____ Birth date _____

Occupation _____

Referred by _____

Emergency contact person _____ Phone _____

Number of children and their ages _____

Are you currently under a physician's care for any condition? Yes No

If *yes*, please describe _____

Physician's name _____ Phone _____ Fax _____

HEALTH HISTORY

Your goal for this session _____

Are you aware of any emotional distress flowing from an injury? _____

Have you suffered from any form of abuse? _____

Any secondary complaints you would like to address? _____

What activities or body positions increase your pain and what activities or positions decrease the pain. _____

Place a mark on the line below to indicate the INTENSITY of the pain right now.

NONE _____ WORST POSSIBLE

Put two marks on the line below to indicate the WORST and BEST your symptoms have been during the past week.

NONE _____ WORST POSSIBLE

Place a mark on the line below to indicate the FREQUENCY of your symptoms.

SELDOM _____ CONSTANT

Mark the lines below to indicate your daily functional ability as a percentage of normal.

On a "good day": 0% _____ 100%

On a "bad day": 0% _____ 100%

- Yes No Do you wear contact lenses?
- Yes No Do you wear dentures?
- Yes No Have you had extensive dental work (*bridges, braces etc*)?
- Yes No Car accident (*at any time*), serious falls, other injuries?
- Yes No Do you have any allergies? If yes, describe: _____

- Yes No Do you have arthritis? Please describe what type and where: _____

- Yes No Do you have any heart problems? Please describe: _____

- Yes No Do you have any spinal problems? Please describe: _____

- Yes No Are you pregnant? How far along? _____ months. Complications? _____

- Yes No Have you had surgery? When _____ Complications? _____

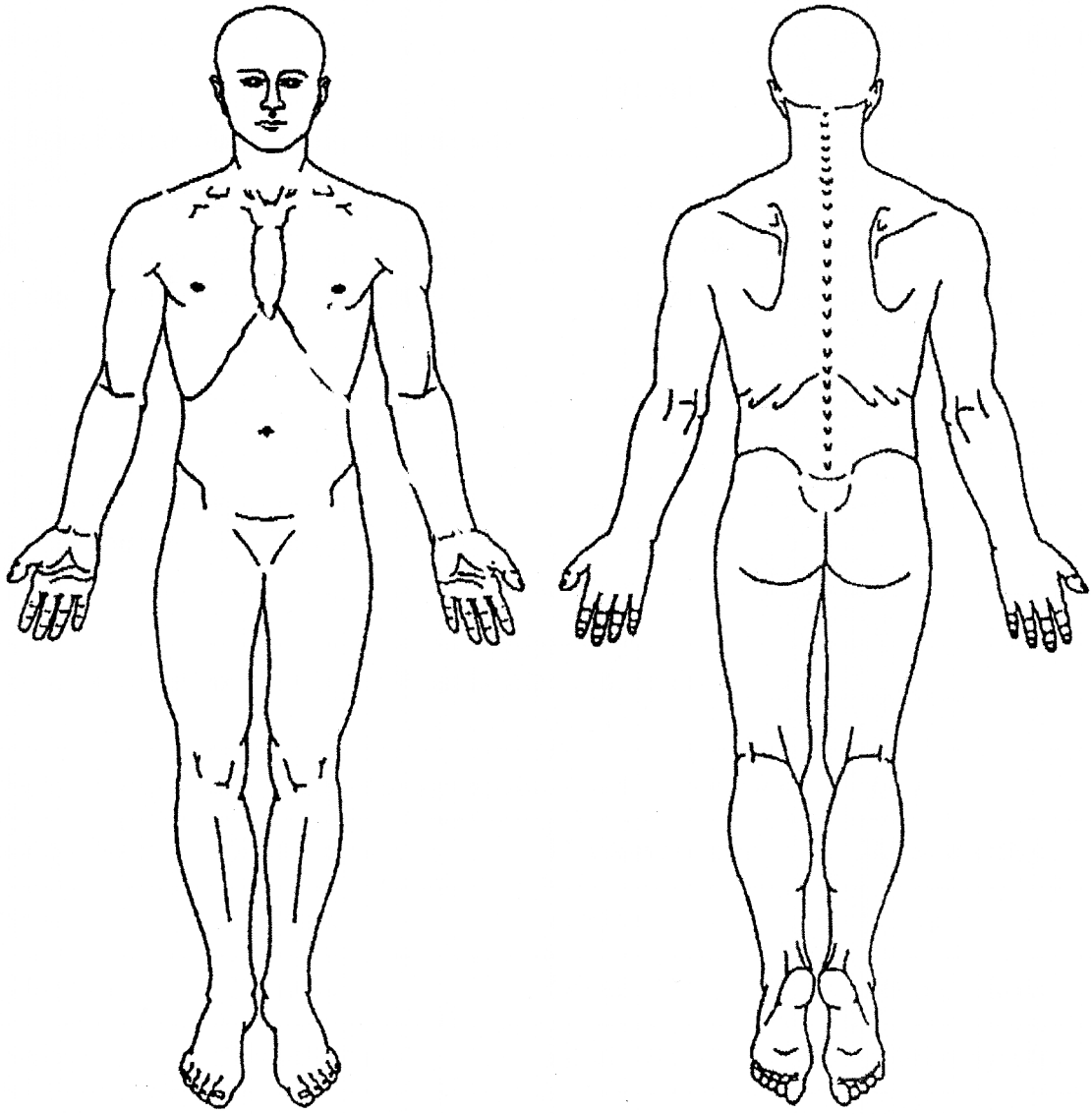
- Yes No Do you take prescribed medicines? List: _____

- Yes No Do you an implanted medical device? Describe: _____

- Yes No Do you exercise regularly? Describe: _____

- Yes No Are you currently receiving other complementary care (*chiropractic, naturopathic, acupuncture, homeopathic, hypnotherapy, nutritional, herbal, other*)? Please describe:

Please circle areas of concern and mark with **P** for Painful, **N** for Numbness or tingling, **W** for Weakness and **S** for Scars



DISCLOSURE & CONSENT

Please thoroughly read the following paragraphs and then initial each paragraph after reading.

_____ I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. In addition, the massage therapist does not prescribe medical treatment or pharmaceuticals.

_____ It has been made very clear to me that massagel therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

_____ Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take upon myself to keep the massage therapist updated on my physical health. Further, I release the therapist from responsibility and liability for any adverse reactions resulting from disclosed and undisclosed conditions.

I have completed the above information accurately and have read, understand and take responsibility for the above statements.

Signature _____ Date _____

Thank you for your cooperation!

CANCELLATION POLICY

I understand that each appointment I have scheduled is very important, either for my own treatment process or that of another who could potentially fill the time slot. I agree to notify Sarah-Jane O'Neil within 24 hours if I need to cancel an appointment. If I am unable to do this I understand that I will be responsible for payment for the schedule time unless Sarah-Jane is able to fill the appointment time.

I have read and understand this cancellation policy.

Name _____ Date _____