# CLIENT HISTORY

Name ______________________________ Date ________
Last First

Address ______________________________
Street City/State/Zip

Date of Birth ______________
Month Date Year

Contact Home ______________ Work ______________

Mobile ______________ Email ______________

How did you hear about us? ______________

Employer/Profession/Work Environment

______________________________

Are you currently under medical treatment that I need to know about? Yes No
If yes, for what condition(s)?

______________________________

______________________________

Are you taking any daily and/or prescribed medication(s) I need to know about? Yes No
If yes, please list and for which condition(s).

______________________________

______________________________

Please list your doctors' name and phone number

______________________________

______________________________

*Are you experiencing or have experienced any of the following:*

| | | |
|---|---|---|
| ______ Arthritis | ______ Heart Problems | ______ Pregnancy |
| ______ Diabetes | ______ Varicose Veins | ______ Skin Problems |
| ______ High/Low Blood Pressure | ______ Cancer | ______ Nausea/Vomitting |
| | ______ Weakness | ______ Numbness |
| ______ Bursitis | ______ Bleeding | ______ Sciatica |

Are you allergic to any foods, oils or lotions? Yes No
If yes, please list

______________________________

Are you involved in a regular exercise program? Yes No
If yes, please list activity(ies) and how often

______________________________

Desired Pressure ______ Light ______ Firm ______ Deep

**PLEASE TURN OVER**

# POLICIES & AGREEMENTS

Please take a moment to carefully review all of the policies. If you have any questions, please ask for clarification. **Please initial EACH statement.**

I understand:

_____ I authorize by signing below the release of my medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information concerning my health and treatment to e sent to my insurance company handling my claim.

_____ All information given on my client history form is correct and up-to-date. I take it upon myself to update any/all changes in my health either prior or during future visits.

_____ This is a non-sexual massage and is for therapeutic purposes only. Therefore, any sexually implicit behavior will result in the immediate termination of the session for which I will be charged in full.

_____ The therapist does not diagnose, treat or prescribe for any illness, ailment, or disease. While the therapist may assist me in relief of physical or emotional symptoms, I understand that the therapist will not "fix" me. This massage is not a substitute for medical care by a licensed health care provider.

_____ Payment is to be paid by cash, credit card, or electronic funds via Zelle after the massage session.

_____ That I have a right to privacy and that my information will be kept confidential, except where required by law.

_____ There is a 24 hour cancellation policy for all sessions. It is my responsibility to cancel my appointments at least 24 hours in advance and failure to do so will result in my being charged in full for the missed appointment. I may send a friend in my place if I am not able to make my appointment.

_____ That my session is reserved especially for me and that I will be ready to begin my session on time. If I am not ready or can not begin my session, my session time will end as scheduled.

_____ This is my session and it is my responsibility to let my therapist know if anything during the session needs adjustment to meet my level of comfort.

_____ That I will not receive or require to keep my session while under the influence of drugs or alcohol and I will be charged in full for my session.

_____ That I will arrive to my session with good personal hygiene

_____ Consent to Treatment of Minor: By my signature below, I hereby authorize the above noted practitioner to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

_____ Any client under the age of 18 is required to have a parent/guardian present in the room for the duration of the session.

I understand and accept all the above policies

_______________________________________
Client Signature Date

_______________________________________
Parent/Guardian Signature Date