Client Information

Name:________________________________ Phone: (____)_____________________ DOB______________________

Address:____City______________________State_______Zip_________

Occupation:_______________________________________Referred by:_____________________________________

Emergency Contact Name __________________________________ **Phone** ______________________________

Physician Name:____ Phone:______________________________

HEALTH INFORMATION

1. Are you under current medical care? **Yes / No** If so, for what condition?: ____________________________________

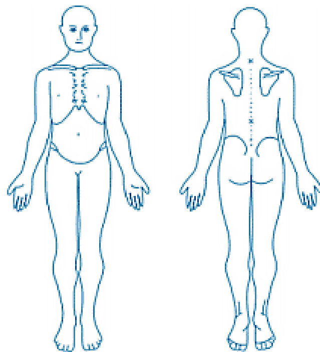
2. Do you see a chiropractor? **Yes / No**

3. Do you have difficulty lying on your **FRONT, BACK, or SIDE ?**

4. Please list any allergies (including fragrances, food, oils, lotions, or ointments):_________________________________

5. Current medications and their purpose ____

6. Mark figure below: **(T)** tension, **(S)** stiffness, **(P)** pain, **(D)** discomfort, **(O)** other _____________



7. List any accidents/operations with approx. date:_____________

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8. On a scale from 1-10 how physically active are you?
   Least 1 2 3 4 5 6 7 8 9 10 Most

9. Please list activities/hobbies:__________________________

10. **What is your goal for this session?:**_________________

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11. Please mark the appropriate box for each of the following below. ***Notify therapist of any changes in the future.***

C	P	**"C" for Current, "P" for Past**	C	P	**"C" for Current, "P" for Past**	C	P	**"C" for Current, "P" for Past**
☐	☐	Allergies	☐	☐	Headaches/Migraines	☐	☐	Blood Clots
☐	☐	Carpal Tunnel Syndrome	☐	☐	Arthritis	☐	☐	Joint pain
☐	☐	Fibromyalgia	☐	☐	Degenerative Disk Disease	☐	☐	Tendonitis
☐	☐	Fracture	☐	☐	Numbness/Stabbing Pain	☐	☐	Heartburn
☐	☐	Jaw Pain or Clicking of Jaw	☐	☐	Any Skin Conditions	☐	☐	Stroke/Heart Attack
☐	☐	Contact Lenses	☐	☐	Epilepsy/Seizures	☐	☐	Cancer
☐	☐	Dizziness	☐	☐	Hypertension	☐	☐	Recent surgery
☐	☐	Pregnancy/ week? _______	☐	☐	Diabetes	☐	☐	Recent Injury w/in 72 hrs.
☐	☐	Muscles spasms	☐	☐	Osteoporosis	☐	☐	Other

Notes:

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Client Information

Acknowledgement

* I understand that therapy administered by the massage therapist is not intended to replace treatment by my physician.

* I grant permission to Cindy Thomas, LMT to release and exchange information regarding my therapeutic sessions with my physician named on this form as needed.

* I understand I am responsible for my own health and well being and release Cindy Thomas, LMT from any liability for my care.

Client Signature____ **Date**______________________________

Therapist Signature____ Date______________________________

Consent to Treatment of Minor:

Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session.

By my signature below, I hereby authorize Cindy Thomas, LMT *to administer therapy techniques to my child or dependent.*

*Signature of Parent of Guardian*____*Date:*______________________

Policies

Sessions: By Appointment. No outcalls are being accepted. Sessions will be booked in increments of no less than 30 minutes.

Payment: Full payment is due at time of service. I accept cash and in-state/area checks. All gift certificates must be presented prior to the massage. Gift certificates are the same as cash. If you do not have a valid certificate in hand, no massage will be given without proper payment of cash or check. Certificates are not redeemable for cash.

Scheduling: You may call or text any time it is convenient for you. If I am unavailable please leave a message and I will return your call as soon as possible. (Text messages are best for quickest reply.)

Late Arrival: If you arrive late, your session may be shortened in order to accommodate the appointments that follow. You will be responsible for the full session fee.

Late Cancellation and Fail to Arrive Policy: Twenty-four (24) hour notice is required of all cancellations. Cancellations with less than twenty-four (24) hours notice, or failing to arrive for a scheduled appointment will result in a fee. First occurrence, $35.00. The second and all future fees will be the full amount of the scheduled service. *Repeated cancellations will be discussed with the client. Such occurrences may result in removal from the client list. ** A reduction in the length of a session without 24 hour notice will have a charge of a full session fee. ***All fees must be paid before any further appointments will be scheduled.***

Whatever your goal…stress relief, pain reduction or relaxation? It's all an investment in your health. Follow through, follow up!

Client Signature____ Date______________________________