Massage Therapy Confidential Client Information

Advanced Wellness Centre

Date:_____ Patient Name:_____

Street:_____City:_____State:_____Zip:_____

Home Phone:_____ Work Phone: _____

Email Address:_____

Age:_____ Height:_____ Weight:_____ Gender: _____

Date of Birth:_____Place of Birth:_____SSN :_____

Occupation:_____ Partner Status:_____

In Case of Emergency Notify: _____

Relation:_____ Phone Number:_____

Family Physician:_____

Concurrent Health Therapies or Regimens:_____

How did you hear about our clinic? Or who referred you?

- ☐ Family Member
- ☐ Friend
- ☐ Physician
- ☐ Health Class
- ☐ Employer
- ☐ Event
- ☐ Insurance Website
- ☐ Brochure
- ☐ Print Ad
- ☐ Sign on Building
- ☐ Internet Web Site
- ☐ Direct Mail Ad
- ☐ Returning Patient
- ☐ TV Commercial
- ☐ Radio
- ☐ Other

If you selected family member/friend/physician please list their name here:_____

If you selected internet website/event or other please describe:_____

Previous experience with massage:_____

Are you currently experiencing stress, pain or tension? _____ Where?_____

Do you have any areas that are sensitive to pressure or limited movement? If so, please list:

_____

Please list any surgeries, accidents or injuries with approximate dates:

_____

PLEASE MARK WITH A "X" ALL CURRENT CONDITIONS AND A "P" FOR PAST CONDITIONS:

- ☐ Acute/chronic pain
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma/Lung Conditions
- ☐ Autoimmune Disorder
- ☐ Cancer
- ☐ Carpal Tunnel
- ☐ Diabetes/Hypoglycemia
- ☐ Digestive Problems
- ☐ Emotional Changes/Depression
- ☐ Fibromyalgia
- ☐ Flu/Cold/Infections
- ☐ Headache/Migraine
- ☐ Heart/Blood Conditions
- ☐ Hepatitis
- ☐ High/Low Blood Pressure
- ☐ HIV
- ☐ Joint Pain
- ☐ Loss of Balance
- ☐ Muscle Aches
- ☐ Neck/Spine Disorders
- ☐ Numbness/Tingling
- ☐ Osteoporosis/Bone Disorders
- ☐ Seizures
- ☐ Skin Conditions
- ☐ Sleeplessness
- ☐ Stroke
- ☐ TMJ Syndrome
- ☐ Varicose Veins/Phlebitis
- ☐ Other_____

I understand that if I experience any pain or discomfort during my session(s) I should inform the Therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that massage/bodywork is not to be used as a substitute for medical examination, diagnosis or treatment by a medical physician, chiropractor, or other qualified health care specialist for any mental or physical ailment. I acknowledge that if I have a mental or physical condition, I should see a qualified physician or health care provider. I have stated all known medical conditions and answered all questions truthfully. I agree to update the Therapist with any changes to my medical profile, and understand there shall be no liability on the Therapist's part should I forget to do so. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment in full.

A 24 hour cancellation notice is required. There will be a $25 cancellation fee without 24 hours notice.

Client Signature:_____ Date:_____

Practitioner Signature:_____ Date:_____