Advanced Massage Therapy

# Massage Information Form

Name:_______________________________________________ DOB:_____________________

Address:________________________________________ City/State:____________ Zip:_________

Phone:________________________________ Alt. Phone:________________________________

Email (To receive updated events and news): ______________________________________________

Employer:________________________________ Occupation:____________________________

Referred By: __Yellow Pages __Advertisement __Friend/Other___________________________________

**PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE APPROPRIATE BOX**

Primary reason for treatment? ____________________________________________________

**Yes No**

__ __ Have you had a professional massage before?

__ __ Do you have any skin allergies or irritations?

__ __ Do you have arthritis or any joint disorders?

__ __ Do you have high blood pressure or other heart problems?

__ __ Do you have varicose veins or blood clots?

__ __ Do you have any spinal problems?

__ __ Do you have frequent headaches?

__ __ Do you exercise or participate in any sports?

If so what kind and how often? ____________________________________________

__ __ Have you had any recent surgeries, broken bones, major accidents, etc...?

_____________________________________________________________________

__ __ Are you currently under a doctor's care? Physician's name: ____________________________

__ __ Do you have any medical conditions of which the therapist should be aware before giving you a massage? ______________________________________________________

__ __ Women only, are you pregnant?

***Provisions on the Massage***

During your massage the therapist may use Swedish, deep tissue, cross fiber, trigger point, Myofascial Release or other approved techniques to facilitate the massage. The therapist will massage the necessary body parts to facilitate the massage excluding any contraindication areas. The therapist will not work the breast area without written consent by the client. Proper draping will be used throughout the whole massage. If at any time the client is uncomfortable with the massage the therapist will discontinue the massage.

I have read and understand the questions above and the statements regarding the provisions of the massage.

________________________________________ ________________________________________

Client Date Therapist Date

***Client Agreement***

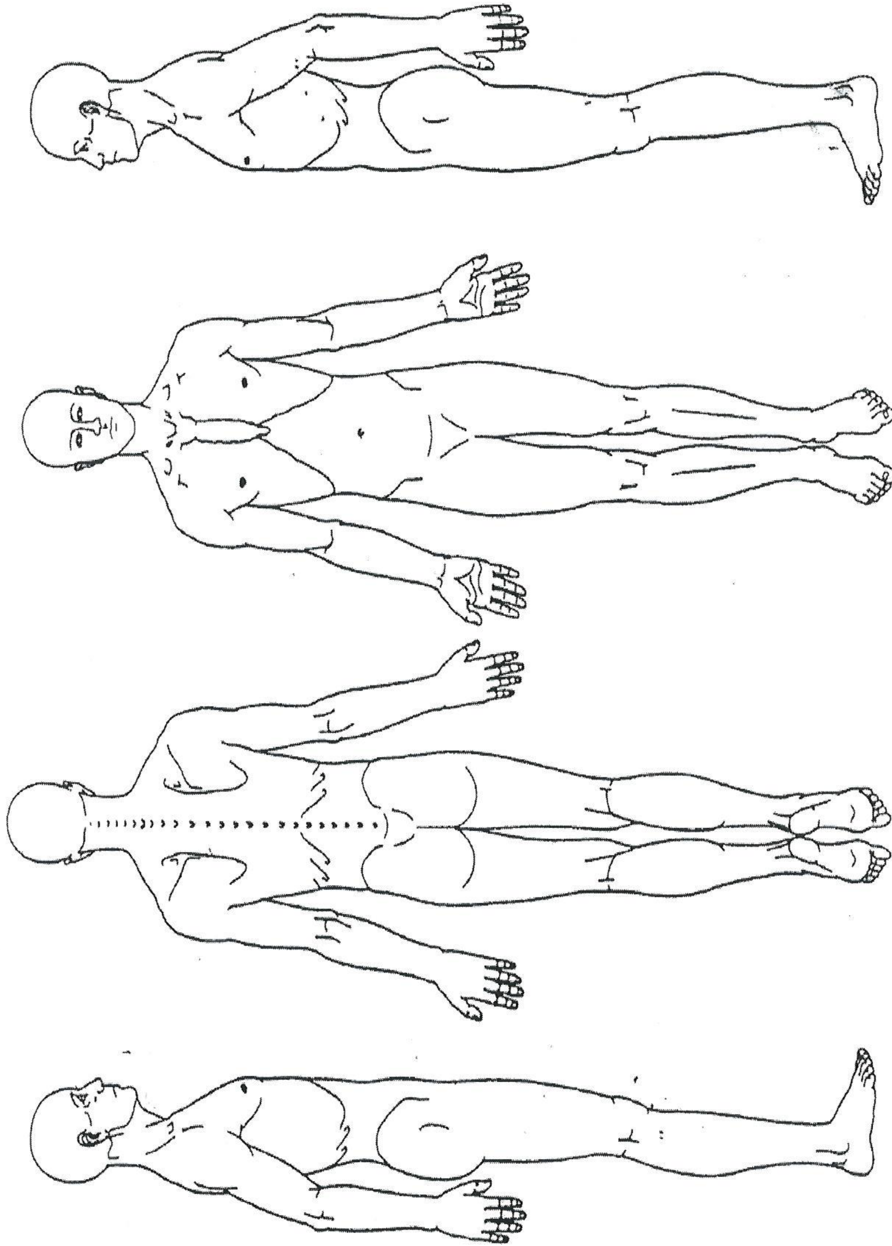
It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. Massage therapy is not a substitute for medical examinations and diagnosis. It is recommended that I see a physician for any physical ailment that I may have. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I understand that the massage therapist does not prescribe medical treatment of pharmaceuticals, nor does the therapist perform any spinal adjustments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. Because massage/bodywork should not be performed under certain medical conditions, I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that Hands On Physical Therapy and Advanced Massage Therapy has provided the form as a reference and is not held liable for any services provided.

________________________________________ ________________________________________

Client Date Therapist Date

# BODY DIAGRAM

Please circle any pain areas, even if you feel they may be unrelated to your chief complaint.



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# Financial Policy

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility. All patients must complete our financial policy before receiving their first treatment.

Massage therapists are part of a service industry who generally receives gratuities as part of their compensation. Please consider a gratuity as part of the total price for your massage service.

**A suggested tip amount is generally 20% if you are happy with the service that you received.**

# Missed Appointments

We require 24-hour notice for appointment cancellations. Our fees for missed appointments or late cancellations are as follows: $150.00 for appointments scheduled with a Massage Therapist per hour. If a two-hour appointment is scheduled, a 48-hour cancellation notice is required.

Three or more missed appointments or late cancellations are grounds for dismissal from our services.

I authorize Hands On Physical Therapy and Advanced Massage Therapy to keep my signature on file and to charge my credit card for any missed appointment fees/late cancellations.

Name: ________________________________ Card Holders Name: ____________________________

Billing Address: ______________________________________________________________________

Credit Card Number: ____________________________________________ Exp:_______ Sec:_________

Card Holders Signature: _________________________________________________________________

**I understand that this form will remain in effect unless I cancel this authorization in written notice.**