Patient Information

Name: _____ D.O.B.: _____

Name of primary insurance holder *(for insurance patients only):* _____ D.O.B.: _____

Patient's Home Ph: _____ Work Ph: _____ Cell Ph: _____

Patient's Gender: _____ Marital Status: _____

Home Address: _____ City: _____ State & Zip: _____

E-mail Address: _____ **Referred By:**

Occupation: _____ Place of Employment: _____

Work Address: _____ City: _____ State & Zip: _____

Emergency Contact: _____ Ph: _____ Relationship: _____

Physician's Name: _____ Ph: _____

Have you ever experienced a professional massage or chiropractic services? _____ If so, when? _____

Do you currently or have you ever had cancer? **YES** **NO** *If yes, we have a special intake form for our oncology patients.*

What is the reason you are here for a massage/chiropractic service? **RELAXATION** **OR** **PAIN RELIEF FOR ACUTE/CHRONIC ISSUES**

_____

Please check the following that apply:

_____ Do you suffer from stress?
_____ Do you experience frequent headaches?
_____ Are you pregnant? What trimester? _____
_____ Are you wearing contact lenses?
_____ Are you wearing dentures?
_____ Do you have high blood pressure?
_____ Do you suffer from epilepsy or seizures?
_____ Do you suffer from joint swelling?
_____ Do you have varicose veins?
_____ Do you have osteoporosis?
_____ Do you have circulatory problems?
_____ Do you have any communicable diseases, including cold or flu?
_____ Do you have arthritis? What type? _____
_____ Do you have diabetes? What type? _____
_____ Do you have any open cuts or lesions? _____
_____ Have you had surgery or been in an accident in the past 2 years?
If yes, please specify: _____
_____ Are you under a Dr.'s care?
If so, for what? _____
_____ Are you currently taking any medications?
If so, for what? _____
_____ Do you have allergies? If yes please list them below.

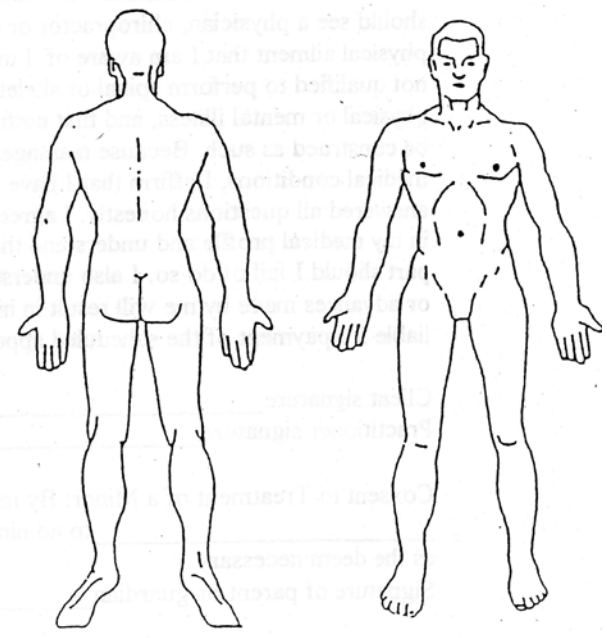
_____

Are you now, or have you ever had a medical condition, symptom or problem with fitness, body structure or health that the therapist should be aware of prior to administering massage therapy? _____

_____

Pressure Preference

☐ **Light** ☐ **Firm** ☐ **Deep**



Please Indicate on the diagram above

_____ Do you have tension, soreness, or pain in a specific area?
_____ Do you have numbness or stabbing pains anywhere?
_____ Are you very sensitive to touch or pressure anywhere?

More on reverse →

Please tell me a little about yourself (optional).
What hobbies and/or sports do you engage in?_____

Please take a moment to carefully read the following information and sign where indicated.

If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral form from your primary care provider may be required prior to service being provided.

I understand that massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session I will immediately inform the practitioner so that the pressure and or strokes may be adjusted to my level of comfort. I further understand the massage or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor, or other qualified healthcare specialist for any mental or physical ailment that I am aware of. I understand that massage/ bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and have answered all questions honestly. I agree to keep practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand 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 for the scheduled appointment.

NSF and Cancelation Notice

Please note that the payee is responsible for a $25 fee plus the original amount of payments for any NSF (Non-Sufficient Funds of personal or business checks) charges.

Please take note that there will be a $35 cancellation fee for any appointment not kept without 24-hour notice to Circle of Wellness. We will be charging your card directly that is on file for the $35 cancellation fee or you may be required to pay it before scheduling any future treatment. Of course, management will take into consideration family emergencies. Please understand that this policy is enforced as courtesy to other clients who may be waiting for that time slot and with adequate notice, we can service them. Thank you for your understanding.

I further agree to be fully responsible for reasonable attorney's fees and costs that have accrued due to the pursuance of payment of my account.

Client signature: _____ Date: _____

Practitioner signature: _____

Consent to Treatment of a Minor (under the age of 18): By my signature below I hereby authorize Circle of Wellness (My Massage Sanctuary to administer massage/bodywork/chiropractic care to my child or dependent as deemed necessary.

Signature of parent or guardian (if client is under the age of 18): _____