Confidential Client Information

Today's Date:_____ Referred By:_____

Name: _____Date of Birth:_____

Occupation: _____

Phone: (Day #)_____EXT_____ HOME WORK CELL

Phone: (Evening #)_____EXT_____ HOME WORK CELL

Cell Phone: _____

The best way to reach me is via (please circle one):

HOME PHONE WORK PHONE CELL PHONE E-MAIL

Address:_____

City:_____ State:_____ Zip:_____

Email address:_____

In case of emergency please contact:_____

at (_____)_____relation:_____

Your privacy is very important to us and we will not rent or sell your personal information.

Would you like to be included on our mailing list? Yes, Please No, Thank you

Please take a moment to carefully answer the following questions and sign where indicated.
If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated.
A referral from your primary care provider may be required prior to service being provided.

WE RESERVE THE RIGHT TO REFUSE OR TERMINATE TREATMENT AT OUR DISCRETION

Have you ever had a professional massage before? Yes No

What do you wish to accomplish with massage? (Circle all that apply) Relaxation Stress Reduction Pain Relief

Have you had any surgery or hospitalization?

More than 10 years ago:

5-10 years ago:

Less than 5 years ago:

Have you ever been involved in an injury or accident?

More than 10 years ago:

5-10 years ago:

Less than 5 years ago:

Do you consider that you have recovered from these events?

Do you have any chronic, ongoing conditions that you deal with on a regular basis?

Are you sensitive to touch or pressure in any area?

Do you have numbness or stabbing pains anywhere?

Are you currently under the care of a doctor for any reason?

Please list and explain any medications you are currently taking:

Circle any of the following conditions that you have experienced:

Skin

Boils
Fungal Infections
Herpes Simplex
Warts
Eczema
Psoriasis
Skin Cancer
Other

Muscle/Skeleton

Fibromyalgia
Rheumatoid Arthritis
Osteoarthritis
TMJ Dysfunction
Strains, Sprains or tendonitis
Carpal Tunnel Syndrome
Thoracic Outlet Syndrome
Osteoporosis
Other

Nervous

Depression
Multiple Sclerosis
Post Polio Syndrome
Headaches
Stroke
Seizure disorders
Reduced Sensation
Sleep Disorders
Other

Circulatory

Anemia
Thrombophlebitis
Deep Vein Thrombosis (DVT)
High Blood Pressure
Low Blood Pressure
Heart Disease
Varicose Veins
Clotting Disorders
Other

Lymph/Immune

Edema
Leukemia/Lymphoma
HIV/AIDS
Chronic Fatigue Syndrome
Lupus
Allergies (oils, fragrances, foods)
Allergies (other)
Other

Respiratory

Asthma
Emphysema
Sinusitis
Tuberculosis
Other

Digestive/Urinary

GERD (reflux)
Ulcers
Crohn's Disease
Ulcerative Colitis
Irritable Bowel Syndrome
Gallstones
Cirrhosis
Hepatitis
Kidney Stones
Renal Failure
Other

Endocrine

Diabetes
Hyperthyroidism
Hypothyroidism
Other

Reproductive

Breast Cancer
Endometriosis
Ovarian Cysts
Prostate Cancer
Painful Menstruation
Breast Augmentation/Reduction
Are you pregnant?
Are you nursing?
Other

Because massage and bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the 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.

Client's Signature _____ Date _____

CONSENT TO TREATMENT OF MINOR: By my signature below, I hereby authorize Heather Horton, LMT to administer massage or bodywork techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date: _____

Massage Therapy Informed Consent

I, _____, (client) understand that massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive, non-sexual experience of touch.

I understand that massage therapy is not a substitute for medical treatment or medications and that it is recommended that I concurrently work with my Primary Caregiver for any condition that I may have.

Certain medical conditions are contraindications for Massage Therapy. I have informed the Massage Therapist of all my known physical or medical conditions, past or present, and any medication that I am currently taking so that the Massage Therapist can explain any possible contraindications. I will keep the Massage Therapist updated on any changes in my health status.

I am aware that the Massage Therapist does not diagnose illness or disease, does not prescribe course of treatment, and that any information communicated will not be construed as such. I understand that Massage Therapists do not perform spinal manipulations.

I understand that sexual harassment will not be tolerated. If romantic or sexually explicit remarks are made or sexual favors are requested or implied, I understand that the session will be immediately terminated. I also understand that if the session is terminated for these reasons that I will be responsible for the full session fee and will be asked not to return for further treatments.

If I experience any physical or emotional pain or discomfort during this session, I will immediately inform the practitioner so that the pressure of the strokes and/or the modalities used may be adjusted to my level of comfort. I also understand that it is within my rights as a client to terminate the session at any point if I so choose.

Your Massage Therapist reserves the right to refuse service or terminate treatment at any time, for any reason, at the therapists sole discretion.

I have received a copy of the therapist's 'Client and Appointment Booking Policies' (see page 4).

By signing below I understand and agree to abide by the above statements as well as the 'Client and Appointment Booking Policies'.

_____ _____

Client Name Date

Client and Appointment Booking Policies

Cancellations

Please allow a minimum of 24 hours for appointment changes and cancellations. Appointments that are canceled or rescheduled in under 24 Hours, or appointments that are a "No Show" are subject to cancellation fees equal to the amount of the original service scheduled.

Appointments

Please arrive 5 to 10 minutes prior to your scheduled appointment so that your appointment may start promptly on time.

Please allow a minimum of 15 to 20 extra minutes for your first appointment with us. This allows time for your therapist to review your health history and customize your treatment plan.

Late Arrivals

Late appointment arrival will result in a shortened treatment session and you will be charged the full amount for the original service scheduled.

Tardiness of more than 15 minutes (without a call to state that you are running late) may forfeit your session and require your appointment to be rescheduled.

Payments

Payment in the form of cash, check, Gift Certificate, Visa, MasterCard, Discover or American Express is accepted and due at the time services are rendered.

There will be a $20.00 fee imposed on all returned checks.

In the event that fees for services or purchased gift certificates are not paid as requested, past due balances will be subject to interest charges. A monthly service charge of 1.5% (18% per annum) will be assessed for all balances should any portion of the balance exceed 30 days or more.

Insurance

I do not currently accept insurance payments for services. I am happy to provide you with a receipt for your session and session notes (SOAP Notes) if you wish to submit to your insurance company for reimbursement.

Office Policies

Clients are to provide a Health History (this will be completed during your first visit) and health updates as necessary.

You have the right to consent to any treatment. If at any point you experience physical or emotional discomfort during your session, inform your practitioner immediately. Understand that your session can be modified or you can end your session at any time.

Sexual Harassment will not be tolerated. If romantic or sexually explicit remarks are made or sexual favors are requested or implied, your session will be terminated immediately. In this instance, you will be responsible for the full cost of the original session scheduled and will be asked not to return for further treatments.

Please do not arrive for your session under the influence of alcohol, illegal drugs or heavily medicated with pain relievers or muscle relaxers. Please inform your therapist if you are currently using pain killers or muscle relaxers.

Please be clean, having showered the same day as your treatment.