



HEALTH HISTORY INFORMATION

OFFICE USE ONLY

SB Entry Referral Email Form Scan

Therapist: _____

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

DOB _____ Email _____

Home Phone _____ Cell/Work _____

Preferred Appointment Reminder(s): Email Text*

*Please list your cell phone carrier: Verizon Sprint Other _____

Occupation _____

Emergency Contact _____ Phone _____

Physician _____

Chiropractor _____

How did you hear about us? *(Please list name)* _____

Are you currently under any medical supervision? If so, please explain:

Are you currently taking any medication? _____

Please list any major surgeries? _____

Reason for your massage treatment today? _____

Have you received massage therapy before? Yes or No

 If yes, how long ago? _____

What type of exercise do you do weekly? _____

Please circle any symptoms presently or recently experienced:

- | | |
|---------------------|--|
| Acne | Heart Disease |
| AIDs (HIV) | High Blood Pressure |
| Allergies | Hives/Shingles |
| Arthritis | Joint Problems |
| Athlete's Foot | Kidney Disease |
| Back Pain/Tension | Lung Disease |
| Cancer/Tumor | Multiple Sclerosis/Parkinson's Disease |
| Constipation | Eczema/Psoriasis |
| Depression/Anxiety | Sprain/Strain or Dislocation of a joint/muscle |
| Diabetes | Stroke |
| Scoliosis | Thyroid Disease |
| Fibromyalgia | Varicose Veins |
| Migraines/Headaches | Other _____ |
| Blood Conditions | |

Pregnancy

Term: 1 2 3

How many weeks? _____

Do you have any of the following:

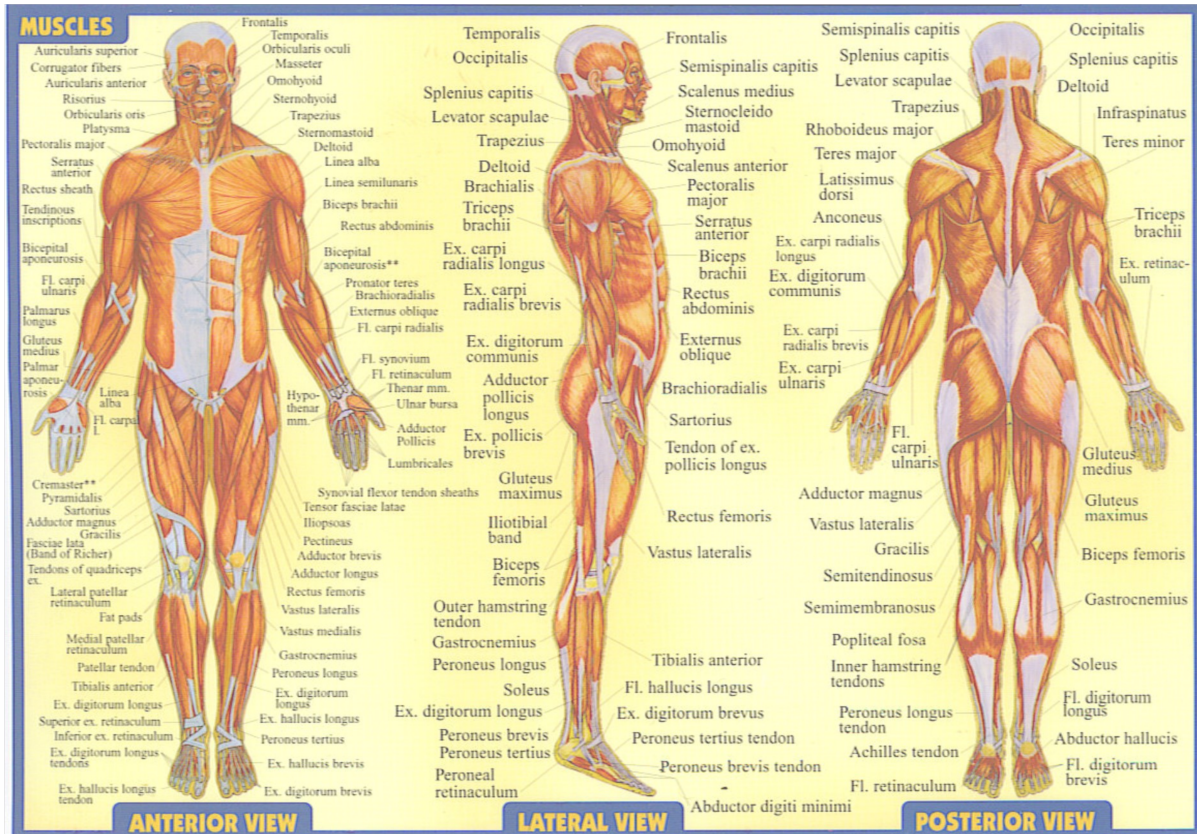
___ Physicians Approval

___ Preeclampsia/Toxemia

___ Premature Labor Symptoms



Please place an "X" below on the areas of tenderness or discomfort.



Clients should also understand that the purpose of the massage is for relaxation and muscular tension. If you experience any pain or discomfort during the session, please immediately inform the therapist. You should further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment and that you should see a physician, chiropractor or other medical specialist for any medical or physical conditions. It is your responsibility to keep your LMT informed of any changes to your health or medication that you begin. There shall be no liability on the practitioner's part should you fail to do so.

APPOINTMENT POLICY

You may cancel your appointments without charge 24 hours in advance for all services performed within Elite. This is a courtesy to other guests and your Practitioner who is reserving time specifically for you.

Same day cancellations will be charged 50% of the scheduled service price.

Appointment reminders are provided via text messaging and e-mail, however, we will not be held responsible for technological difficulties.

Please write your appointment time down in a secure location.

If you do not call to cancel your appointment at least 2 hours prior to the scheduled time or do not show up for your scheduled appointment, you will be charged full price for the service.

By signing this form, you are agreeing to these terms and conditions.

Signature _____ Date _____

EXCLUSIVE ELITE OFFER

SAVE \$10 ON YOUR
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ONLY!**

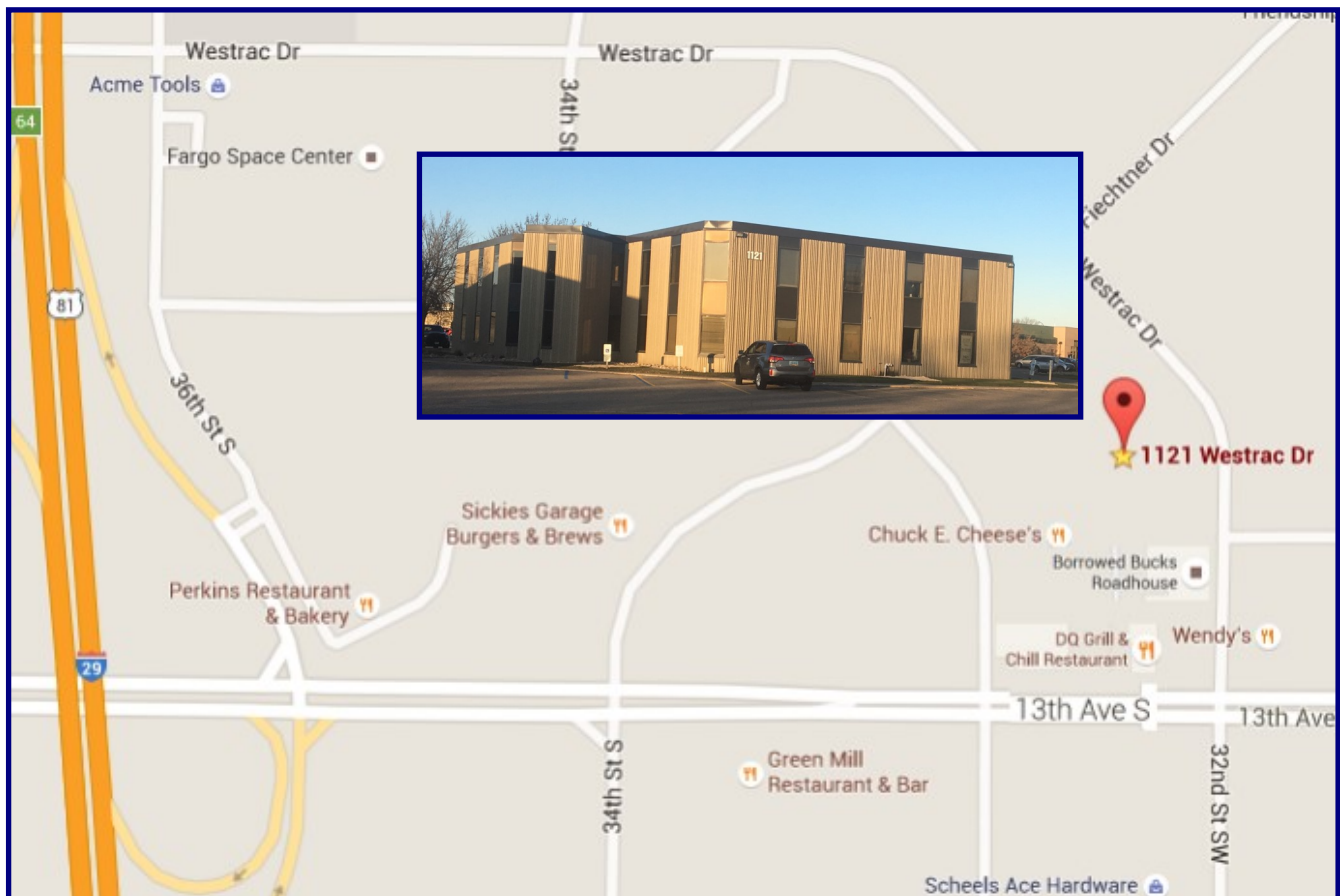
ELITE
Therapeutic Massage
& Health Partners



Introductory
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701.297.8191

*Not redeemable on Couples Massages, Specialty Services, Body Waxing, Make-up Application, or Make-up Products. May not be combined with any other offer. Other exclusions may apply.



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