Danielle K. Berry
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WWW.BESTBACKANDBODY.COM
512-692-9100

DATE: _____

PATIENT CONTACT INFORMATION:

Patient Name: _____ **Gender:** _____ **DOB:** _____

Address: _____

Phone#: _____ **Email:** _____

Occupation: _____ **Referred By:**_____

EMERGENCY CONTACT INFORMATION:

Name: _____ **Phone#:** _____

Relationship to Patient: _____

MASSAGE INFORMATION: CIRCLE ANSWERS

Have you ever received a professional massage or bodywork before? YES NO

If yes, how long ago? _____

What type of massage/bodywork do you prefer or have had in past?

SWEDISH (RELAXATION) DEEP TISSUE PRENATAL FST (FASCIALSTRETCH THERAPY)

CUPPING FAKTR (FUNCTIONAL AND KINETIC THERAPY REHAB) TPT (TRIGGER POINT THERAPY)

What type of pressure do you prefer? LIGHT MEDIUM FIRM DEEP

What do you feel today? STRESS TENSE TIGHT PAIN NUMB TINGLING

Where are you feeling these issues? _____

_____

Do these symptoms interfere with your daily activities? YES NO

HEALTH HISTORY:

List any medications and/or supplements you are currently taking:

_____

_____

_____

Are you or could you be pregnant? YES: How many weeks? _____ **NO N/A**

Do you have any allergies/aversions to any LOTIONS/OILS/FRAGRENCES? If yes, please list _____

Is it ok to use CBD lotion or oil during your sessions? YES NO

Have you had any injuries, sprains, strains or surgeries in the past? If yes, please explain with specific area affected and date of injury/surgery.

_____

_____

_____

Please CIRCLE any of the following health conditions you may currently have OR had: Please remember your answers are confidential so answer honestly, as massage may be contraindicated for your condition.

CURRENT	PAST	N/A	SWELLING:
CURRENT	PAST	N/A	BRUISE EASILY:
CURRENT	PAST	N/A	SENSITIVE to TOUCH/PRESSURE (WHERE):
CURRENT	PAST	N/A	SENSITIVE to HOT/COLD:
CURRENT	PAST	N/A	HIGH/LOW BLOOD PRESSURE:
CURRENT	PAST	N/A	STROKE/HEART ATTACK (DATE):
CURRENT	PAST	N/A	VARICOSE VEINS (WHERE):
CURRENT	PAST	N/A	SHORTNESS OF BREATH/ASTHMA:
CURRENT	PAST	N/A	CANCER (TYPE/WHERE):
CURRENT	PAST	N/A	NEUROLOGICAL CONDITION (e.g. MS, PARKINSONS, FIBROMYALGIA):
CURRENT	PAST	N/A	EPILEPSY/SEIZURE (DATE OF LAST OCCURANCE):
CURRENT	PAST	N/A	HEADACHES/MIGRAINES:
CURRENT	PAST	N/A	DIZZINESS/RINGING IN THE EARS:
CURRENT	PAST	N/A	ARTHRITIS (RHEUMOTOID/OSTEOARTHRITIS):
CURRENT	PAST	N/A	OSTEOPENIA/OSTEOPEROSIS:
CURRENT	PAST	N/A	SPINAL DISC (TYPE of ISSUE) (WHICH DISCS):
CURRENT	PAST	N/A	SCOLIOSIS (DEGREE of CURVE):
CURRENT	PAST	N/A	ALLERGIES (SEASONAL, FOOD, MEDICATION):
CURRENT	PAST	N/A	DEPRESSION/ANXIETY/PHOBIA (TYPE):
CURRENT	PAST	N/A	MEMORY LOSS/CONFUSION/EASILY OVERWHELMED:
CURRENT	PAST	N/A	BLOOD CLOTS
CURRENT	PAST	N/A	CONGESTIVE HEART FAILURE
CURRENT	PAST	N/A	PITTED EDEMA
CURRENT	PAST	N/A	CONTAGIOUS DISEASE TYPE:
CURRENT	PAST	N/A	SEXUALLY TRANSMITTED INFECTION TYPE:
CURRENT	PAST	N/A	OTHER:

CONSENT FOR TREATMENT:

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.

If I become uncomfortable for any reason during the session, I will immediately inform the practitioner so that the session may cease.

During each session the breasts, genitals and glutes (buttocks) shall always be draped. If massage is indicated in the pectoralis (breast) muscles, the patient will be verbally informed of intent before session as well as need to initial and date the S.O.A.P. note before each session allowing Practioner to perform pectoralis massage.

I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see physician, chiropractor, or another qualified medical specialist for any mental or physical ailment of which I am aware.

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 should be construed as such.

Since massage/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.

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 of the scheduled appointment.

I have a full understanding of all this, and I give my consent to receive care.

PATIENT SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

CANCELLATION POLICY:

Best Back&Body understands that life happens, and we will do our best to accommodate your scheduling needs. However, we do ask for a 24-hour cancellation notice. The first violation of this policy will result in a warning. The second violation will result in a 50% charge for whatever bodywork you had scheduled. The third violation will result in a 100% charge for whatever bodywork you had scheduled. Three no call, no shows in a row and unfortunately, we will no longer be able to schedule you as a patient with this practice.

I have read the above cancellation policy. I understand and agree to its terms and will do my best to abide by them.

PATIENTS SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____