# Healing Therapeutics

75 Hassan St SE, Hutchinson, MN 55350

## MASSAGE THERAPY CLIENT INFORMATION

### Personal Information:

Name: _____ Telephone (  )_____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Referred By: _____ Telephone (  )_____

In case of Emergency: _____ Telephone: _____

Email:_____

**General & Medical Information:**

Occupation: _____ Age: _____ Circle: Male Female

Physician Name & Address: _____

What brought you in today: _____

Have you ever experienced a professional massage session? Circle: Y N How recently? _____

Please list any Sports or Regular activities you do: _____

*Please review the following questions and circle Yes or No. If you answer "Yes", please explain as clearly as possible in the lines provided.*

Yes No Do you have diabetes? If so, when was your last injection today? _____

Yes No Do you experience frequent headaches? _____

Yes No Are you pregnant? If so, please indicate how many weeks you are pregnant _____

Yes No Do you have allergies? Please list any _____

Yes No Have you had any broken bones in the past two years? _____

Yes No Have you been in an accident or suffered any injuries in the past two years? _____

Yes No Do you have tension or soreness in a specific area ? Please specify _____

Yes No Have you ever had surgery? Please specify _____

Yes No Do you have any other medical conditions or are you taking any medications I should know about? Please be specific _____

Please add any additional comments that you think may be relevant:

_____

*If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.* I understand that eh massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a chiropractor, medical doctor, or other qualified medical specialist for any mental or physical ailment that I aware of. I understand that massage 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. Because massage should not be preformed 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 my 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.

**Client Signature**: _____ Date: _____

**Practitioner Signature**: _____ Date: _____

**Consent to Treatment of Minor**: By my signature below, I hereby authorize Healing Therapeutics massage therapist to administer massage, bodywork, or somatic therapy techniques to my child or dependent, as they deem necessary.

Signature of Parent or Guardian: _____ Date: _____

## 24 – Hour Cancellation Policy

All cancellations and "no shows" will be billed at current rates if not notified within 24 hours. I agree to these terms and understand my account will be billed under the conditions stated.

Signature: _____ Date: _____