



# Massage Therapy Client Information



Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_

Referred by: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

What kind of pressure do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving massage/bodywork? \_\_\_\_\_

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

List the medications you currently take: \_\_\_\_\_

Have you had any **injuries, surgeries or diagnoses** in the past that may influence today's treatment?

Circle any of the following health conditions that you currently have (If you are unsure, please ask): blood clots, infections, congestive heart failure, contagious diseases, pitted edema, pregnancy (# of months) \_\_\_\_\_.

Please indicate any conditions that you have or have had in the past. Circle "past" or "current" condition.

- |  |   |
|--|---|
| Current Past Muscle or joint pain                | Current Past Digestive conditions (e.g. Crohn's, IBS)   |
| Current Past Muscle or joint stiffness           | Current Past Gas, bloating, constipation                |
| Current Past Numbness or tingling                | Current Past Kidney disease, infection                  |
| Current Past Swelling                            | Current Past Arthritis (rheumatoid, osteoarthritis)     |
| Current Past Bruise easily                       | Current Past Osteoporosis                               |
| Current Past Sensitive to touch/pressure         | Current Past Degenerative spine/disk                    |
| Current Past High/Low blood pressure             | Current Past Scoliosis                                  |
| Current Past Stroke, heart attack                | Current Past Broken bones                               |
| Current Past Varicose veins                      | Current Past Allergies                                  |
| Current Past Shortness of breath, asthma         | Current Past Diabetes                                   |
| Current Past Cancer                              | Current Past Endocrine/thyroid conditions               |
| Current Past Neurological (e.g. MS, Parkinson's) | Current Past Depression, anxiety                        |
| Current Past Headaches, Migraines                | Current Past Memory Loss, confusion, easily overwhelmed |
| Current Past Dizziness, ringing in the ears      |   |

### Consent for Treatment

*If I experience pain or discomfort during this session, I will communicate with the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, PT, or other qualified medical specialist for any mental or physical ailment. 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 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. Understanding all of this, I give my consent to receive care.*

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Signature (if minor): \_\_\_\_\_ Date: \_\_\_\_\_

**Rates payable to Jane Hopkins. Cash, checks, Venmo, Zelle accepted.**

**1/2 Hour - \$50.00**

**1-Hour - \$90.00**

**90 min - \$135.00**

*Credit cards will incur an additional 3% fee. Thank you for your understanding.*

### **Cancellation Policy**

*We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all clients, the following policies are honored:*

**24-hour advance notice is required** when canceling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24 hours advance notice you will be charged the **full amount** of your appointment. This amount must be paid prior to your next scheduled appointment.

### **No-shows**

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show." They will be charged for their "missed" appointment.

### **Late Arrivals**

If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, **you will be responsible for the full amount**. Out of respect and consideration to your therapist and other customers (this is not a punishment, it is a consequence), **please** plan accordingly and be on time. If you know you will be late, please contact your therapist immediately to see if arrangements can be made to still be seen.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

***I look forward to meeting you!***