Time To Relax

612 638 7981

Health Information

Client Contact Information

Client Name: _____ Date: _____

Date of Birth: _____ Gender: _____ Occupation:_____

Address: _____

Phone: _____ Email: _____

Referred by: _____

Emergency contact: _____ Phone: _____

Permission to Email Monthly Newsletter? YES____ NO____

Massage Information

Have you ever received professional massage/bodywork before? Yes □ No □
How recently? _____
What types of massage/bodywork do you prefer? _____
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 including what they are for as well as any past surgeries:

_____ _____

_____

Are you wearing contacts? Yes □ No □ Are you wearing dentures? Yes □ No □
Are you wearing a hairpiece? Yes □ No □ Are you pregnant? Yes □ No □

Health History

Have you had any injuries or surgeries 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

Please answer honestly, as massage may not be indicated for the above conditions.

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current Past Muscle or joint pain/stiffness _____

Current Past Numbness or tingling _____

Current Past Swelling _____Current Past Bruise easily _____

Current Past Sensitive to touch/pressure_____ Current Past Varicose veins _____

Current Past High/Low blood pressure _____Current Past Stroke, heart attack _____

Current Past Shortness of breath, asthma _____Current Past Cancer _____

Current Past Neurological (e.g. MS, Parkinson's, chronic pain) _____

Current Past Epilepsy, seizures _____Current Past Headaches, Migraines_____

Current Past Dizziness, ringing in the ears _____ Current Past Kidney disease, infection_____

Current Past Digestive conditions (e.g. Crohn's, IBS) _____Current Past Gas, bloating, constipation_____

Current Past Arthritis (rheumatoid, osteoarthritis) _____

Current Past Osteoporosis, degenerative spine/disk _____

Current Past Scoliosis _____Current Past Broken bones _____

Current Past Allergies _____ Current Past Diabetes_____

Current Past Endocrine/thyroid conditions _____ Current Past Depression, anxiety_____

Current Past Memory Loss, confusion, easily overwhelmed _____

Comments:

_____

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. 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, chiropractor, or other 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 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.

Cancellation & Payment Policies

Your appointment time is scheduled especially for you. I understand that unplanned events happen sometimes and there is an occasional need to cancel or reschedule an appointment. Out of respect for your therapist and other clients, please read and sign the following policy.

- If cancellation is necessary, please give 24-hour notice or you will be charged **100% of the appointment fee** regardless of the length of the appointment unless it can be filled.
    - **Emergency cancellations are determined at the practitioner's discretion.**
    - **If you are sick within less than 24 hours of your appointment and need to reschedule, please let me know via phone or text as soon as possible.** Questions, contact me at 612 638 7981.
- If a client does not arrive within 15 minutes of the scheduled appointment time, the client is charged for the full appointment, even if the appointment must be shortened or rescheduled.
- Full payment is expected at the time service is rendered.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____