

Name _____ Date _____
Street _____
City _____ State _____ Zip _____
E-Mail _____
Phone (day) _____ (eve) _____ (cell) _____
Date of Birth ____/____/____ Marital Status: ____ Single ____ Married ____ Divorced
Occupation _____ Employer _____
Children's Names and Ages _____
Name of Spouse/Significant Other _____
Preferred Appointment Day and Time: _____
In Case of Emergency: _____ Phone _____

***Please List Any Changes You Have Had In Any Of The Areas Below Since Your Last Visit
Use back of page if need more room for description of changes***

- 1. Exercise habits:
- 2. General diet:
- 3. How well you sleep:
- 4. Your general health:
- 5. How are your bowels?
- 6. Posture assumed most of day:

Medical Health History: Events since your last visit

Please Explain and GIVE DATES

- Describe any surgeries or hospitalizations:
- Describe any injuries or accidents:
- What kind of care did you receive?
- Do you consider that you have recovered from these events? Please explain
- Do you have any **NEW** muscle pain and/or stiffness? Explain
- Do you have any **NEW** chronic, ongoing conditions that you deal with on a regular basis? Please explain.
- What medications are you currently taking? Please list, give details

- Are you currently seeing a doctor for any reason? Please explain.
- If the need arises, do I have your permission to contact your physician?
Name _____
Address _____
Phone _____

- Do you have any skin rashes or other skin problems right now?

- Do you have any trouble lying on your back, front or turning over?
- Do you experience frequent headaches? Yes or No
- Are you a diabetic? Yes or No
- Do you have high blood pressure? Yes or No
- Do you have cardiac or circulatory problems? Yes or NO
- Do you have high cholesterol? Yes or No

Healing Hands Massage Therapy
Policies and Disclaimer

Name: _____

Please initial after each policy to say that you read and understood the policy

All information you give to me will be treated confidentially. In order to maximize the effectiveness and safety of your massage session, please give feedback before, during and at the end of the session. This will help me to better understand your needs and how to better serve you in the best possible way. _____

If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided. _____

I understand that giving 24 hours notice or more for cancellations or rescheduling will not result in any charge for that appointment. _____

Any missed appointment without 24 hours notice will result in a **\$50.00**
No Show fee. _____

Punctuality will assure full use of the allotted time. I allow 15 minutes for tardiness before I mark you as a No Show. I will make a phone call to the phone number on your chart to see if you are coming and if needed to reschedule. Any missed time due to you being late will be deducted from your session time. You will still be charged the same session price. If I am running late; you will still get your full session time

Missed appointment and clients running late is not only a hardship for your therapist but it's also unfair to those other clients who have an appointment after you or those on my waiting list who would have liked to have been notified of the opening. _____

Any returned check will result in a charge of \$25.00; I will then only be able to accept cash or charge for payment. _____

I have read the above information and will discuss it with my practitioner. I understand that massage/movement therapies I receive are provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/ or strokes may be adjusted to my level of comfort. I further understand that massage/movement therapies should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/movement therapists 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/movement therapy 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapists part should I neglect to do so. I understand that massage/ movement therapies are designed to be health aids and do not constitute medical treatment. I understand that information exchanged during massage sessions is educational in nature and intended to help me become more familiar with and conscious of my own health status, and is to be used at my discretion. I take responsibility for alerting my therapists immediately if I am feeling ill. I understand that I cannot hold my practitioner liable for undisclosed conditions or irresponsible acts I might perform. It is also understood 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.

Signature _____ Date _____ Therapists in _____

Healing Hands Massage Therapy Sarah E. Otis, CMT, LMT, NCBTMB
Bristol, VA 24201 423-646-9961
www.healinghandsmassage-bristol.com

General Release of Information

Today's Date: _____

Client Name: _____ *Please Print*

Please initial after each and sign at the bottom

1. I give Healing Hands Massage Therapy permission to speak or exchange any and all needed information pertaining to my current health conditions that I am seeing my regular physician for, if the need arises. _____

ANYTHING NON-HEALTH RELATED DISCUSSED DURING INTAKES OR SESSIONS WILL NEVER BE DISCUSSED WITH YOUR PHYSICIAN UNLESS YOU ARE POSING A HEALTH RISK TO YOURSELF.

2. I give Healing Hands Massage Therapy permission to call my physician, 911 or my Emergency Contact Person on file during an emergency situation for assistance. Only the needed information will be released for your care. _____

3. I give Healing Hands Massage Therapy permission to mail my physician a letter stating that I am being treated by Sarah E. Otis, CMT, LMT, NCBTMB, to give my physician an opportunity to voice any concerns about my current health conditions contraindicating massage.

Physician's Name, Address and Phone Number:

Emergency Contact, Address and Phone Number:

I understand that I may withdraw this consent at any time except to the extent that the authorized parties have already acted in reliance on it.

This authorization will automatically terminate in six (6) months, at that time you will need to sign another release of information

Name

Date