

Client Information

Name _____ Phone (____) _____ DOB _____

Address _____ City _____ State _____ Zip _____

E-mail: _____

Referred by: _____ Phone (____) _____

In case of emergency: _____ Phone (____) _____

Occupation _____ Male Female Physician _____

Health Insurance Carrier _____

Please take a moment to carefully read the following information and sign where indicated. 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.

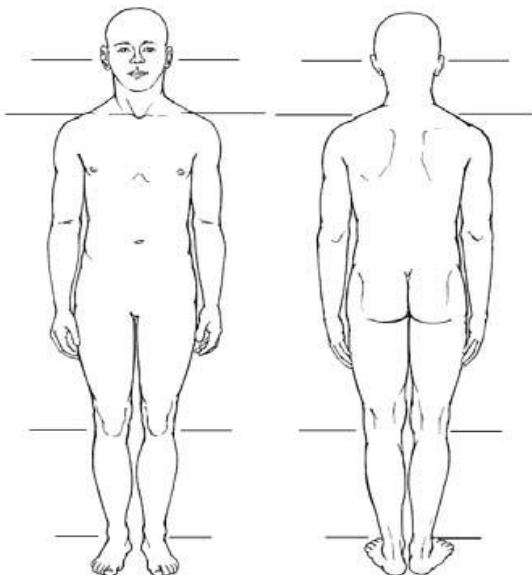
Have you ever experienced a professional massage or bodywork session? Yes No How recently? _____

What are your massage or bodywork goals? _____

What kind of pressure do you prefer? light medium firm

If you answer "yes" to any of the following questions, please explain as clearly as possible.

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you frequently suffer from stress? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you bruise easily? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No Any broken bones in the past two years? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience frequent headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No Any injuries in the past two years? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have tension or soreness in a specific area?
Please specify _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from arthritis? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have cardiac or circulatory problems? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing contact lenses? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from back pain? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing dentures? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have numbness or stabbing pains? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you sensitive to touch or pressure in any area? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking high blood pressure medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? Explain below. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from epilepsy or seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No Other medical condition, or are you taking any
medications I should know about? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from joint swelling? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have varicose veins? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any contagious diseases? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have osteoporosis? | Comments _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any allergies? | _____ |



Identify CURRENT symptomatic areas in your body by marking letters on the figures. Use the letters provided in the key to identify the symptoms you are feeling today.

KEY:
 P = pain or tenderness
 S = joint or muscle stiffness
 N = numbness or tingling

***Cancellation Policy**

We understand that unanticipated events happen occasionally in everyone’s life. Business meetings, project deadlines, flight delays, car problems, snowstorms, and illness are just a few reasons why one might consider canceling an appointment. In our desire to be effective and fair to all of our clients and out of consideration for our therapists’ time, we have adopted the following policies:

***24 hour advance notice is required** when cancelling 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 for the full session.

***Arriving late**

Appointment times have been arranged specifically for you. 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” session.**

*Out of respect and consideration to your therapist and other clients, **please** plan accordingly and be on time.*

***Office Hours:**

Monday, Tuesday, Thursday

9:30- 1pm and 3-6:30

Friday 9:30 – 1pm

1st **Saturday** of the Month 9:30-1

*Massage Rates:
½ an hour: 35.00
1 hour: 60.00
1 ½ hours: 90.00

AromaTouch Technique: 75.00
Therapeutic Massage combined with AromaTouch Technique: 110.00

Payment is due at time of service. For your convenience we accept cash, check, Visa, and MasterCard.

***I understand that the massage/bodywork I receive is 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 practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examinations, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialists 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. **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 the immediate termination of the session and I will be liable for payment for the scheduled appointment.**

Client signature _____ Date _____

Practitioner’s signature _____ Date _____

***Consent to Treatment of Minor:** By my signature below I hereby authorize Debra Tafoya to administer massage/bodywork to my child or dependent _____ as they deem necessary.

Signature of Parent or Guardian _____ Date _____

***CHIROPRACTIC PATIENTS:**

NUCCA and **massage** work great together! You’ll receive the greatest benefits by scheduling your massage on the same day as your adjustment. We suggest furthering your health care benefits by allowing **Dr. Jamie Cramer** and **Debra Tafoya** to work as a team; discussing your care as professionally dictated.

I give permission to Dr. Jamie Cramer and Debra Tafoya to discuss my case in order to further my health care benefits.

Signature/Date _____