

**CONFIDENTIAL MASSAGE CLIENT INFORMATION**

Date \_\_\_\_\_

Driver's License # \_\_\_\_\_

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

*First**Middle**Last*Check if you are:  Male  Female  Married  Single  Widowed  Divorced  Partnered

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name and Phone # of Person To Contact In Case of Emergency \_\_\_\_\_

How were you referred to this office? \_\_\_\_\_

Family Physician \_\_\_\_\_

Have you ever experienced a professional massage?  Yes  No If yes, how recently? \_\_\_\_\_**GENERAL MEDICAL INFORMATION**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Stress              | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Arthritis                           |
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Joint swelling     | <input type="checkbox"/> Diabetes                            |
| <input type="checkbox"/> Contagious disease  | <input type="checkbox"/> Back pain          | <input type="checkbox"/> Very sensitive to touch or pressure |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Bruise easily      | <input type="checkbox"/> Epilepsy or seizures                |
| <input type="checkbox"/> Wear contact lenses | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Cardiac or circulatory problems     |
| <input type="checkbox"/> Pregnant            | <input type="checkbox"/> Depression         | <input type="checkbox"/> Varicose veins                      |

 Numbness or stabbing pains. Specify below. Tension or soreness in a specific area? Specify below. High blood pressure. If "yes", taking medication for this? Surgery in the past five years? Explain below. Accident or suffered any injuries in the past 2 years? Broken bones, etc. Other medical conditions not listed.**CONSENT TO TREATMENT**

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If experience any pain or discomfort during the 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 should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that massage 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 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 massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapist's part should I fail to do so. I understand that the License Massage Therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

\_\_\_\_\_  
**CLIENT'S SIGNATURE**\_\_\_\_\_  
**DATE**

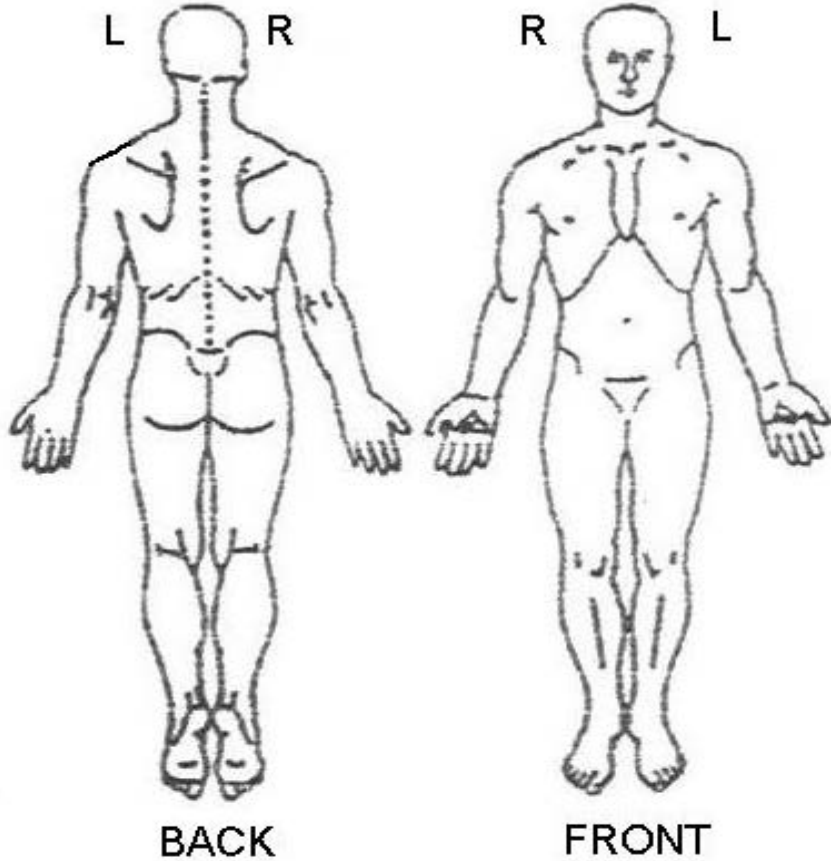
# ARENA CHIROPRACTIC WELLNESS CENTER

Massage Therapy

## PAIN DIAGRAM

Using the symbols listed below, mark on the two drawings which areas on your body where you feel the described sensations:

- Numbness           = = =
- Dull Ache           0 0 0
- Hot Burning       x x x
- Sharp Stabbing   / / /
- Pins & Needles   + + +
- Other             \_\_\_\_\_



Please pinpoint your area(s) of pain

### Pain Scale:

Please rate the severity of the pain you have felt, in general, by checking one box on the following scale:

No Pain					Excruciating Pain					
0	1	2	3	4	5	6	7	8	9	10

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

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

# Arena Massage Cancellation Policy

We understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, bad weather, and illness are just a few reasons why one might consider rescheduling or cancelling an appointment. When a massage appointment is scheduled, that time is exclusively reserved for you. 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 the massage therapist to fill your appointment slot if you need to reschedule. If you are unable to give us 24 hours advance notice, you will be charged the full cash rate for your missed massage.

Confirmation calls are a courtesy that our staff does if the schedule permits time to do so. If you do not receive a confirmation call, you are still responsible for coming to your appointment on time. Not receiving a confirmation call is not an excuse for missing your appointment and you will be charged the full cash rate for your missed massage.

## **No Shows**

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no show", and you will be charged the full cash rate for your missed massage.

## **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 massage therapist and other clients, please plan accordingly and be on time.*

WE LOOK FORWARD TO WORKING WITH YOU!

X \_\_\_\_\_

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