CONFIDENTIAL CLIENT INFORMATION

First Name: _____ M.I.____ Last Name: _____ Date of Birth: _____

Mailing address: _____ City: _____ State: _____ Zip:_____

Phone: _____ Is it ok to text? Y N Is it ok to leave a message? Y N

Referred by: _____ Is this your first professional massage: Y N

How will you be paying: ☐ Cash/Credit ☐ Regence ☐ HMA ☐ Auto claim ☐ LNI claim

*We also accept HSA and FSA cards for payment

Reason for visit: _____

Will this be a pre-natal massage? Y N When is your due date? _____

Have you had any recent surgeries? Y N What was worked on? _____

Describe the activities that cause this pain and/or make it worse: _____

_____

Do any activities make the pain better? _____

_____

Are you currently under the care of a doctor for this issue? Y N Dr's Name:_____

Are you currently taking any of the following medications: (circle any that apply) blood pressure? blood thinners? pain relievers? anti-inflammatories? muscle relaxers? beta-blockers? diabetes medications?

Other medications: _____

*If this is part of an auto claim or LNI claim, please fill out the claim fact sheet and if necessary the 3rd party claim payment agreement.

Intl _____ I have read and understand the Privacy Policy

Intl _____ I have read and understand the Prescription Policy

Intl _____ I have read and understand the No-Show/Cancellation Policy

Intl _____ I have read and understand the 3rd party agreement if filing an auto or LNI claim

*I consent to treatment at this facility and certify that the above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medication, or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health.

Signature: _____Date: _____

Parental Signature if a Minor: _____Date: _____