



Dynamic Touch

Massage Experts

Client Information

Name: _____ Date of Birth: _____ Occupation: _____

Address: _____ Home Phone: (____) _____

City: _____ Zip: _____ Work Phone: (____) _____

e-mail _____ Referred by: _____ Cell Phone: (____) _____

opt out

General & Medical Information

Age: _____ Male Female Ladies Only: Are you pregnant? Yes No Due Date _____

Have you ever experienced a professional massage or body work session? Yes No How Recently? _____

Which type of massage do you prefer? Light Touch Firm Touch Other _____

Do you exercise Regularly? Please describe _____

Do you frequently suffer from stress? Yes No Do you have high blood pressure? Yes No

Have you been in an accident or suffered any injury in the past two years? Yes No Do you have cardiac or circulatory problems? (including varicose veins) Yes No

Do you experience frequent headaches? Yes No Do you have diabetes? Yes No

Do you bruise easily? Yes No Have you ever had surgery? Yes No

Do you have any allergies? (especially fragrances or oils) Yes No Do you suffer from arthritis? Yes No

Do you have numbness or stabbing pains anywhere? Yes No Are you taking any medication? Please list below. Yes No

Are you sensitive to touch or pressure in any area? Yes No Do you have any other medical condition I should be aware of? Yes No

Do you have any broken skin? (e.g., rashes or wounds) Yes No Have you ever been treated for cancer? Yes No

Do you have any old injuries I should know about? Yes No If yes, please complete the additional form. Do you have any fungus on feet or nails? Yes No

Where in your body do you hold tension? _____ Which is your dominant hand? Left Right

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

Comments:

What is/are your main goals for the session today, and long term?

Client Signature _____ Date _____ Parent/Guardian _____

For Office Use Only

MT: _____ F/U Date: _____ TYC Date: _____ Scan Upload MBOinput



Disclosures

I understand that the massage/body work that 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 body work is not medical treatment and should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a qualified medical specialist for any mental or physical ailment that I am aware of. I affirm that I have stated all my known medical conditions, and answered all questions honestly and completely. 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 forget to do so. 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 the payment of the scheduled appointment.

Client Initials _____

Cancellation Policy

24 hours notice is required for all cancellations. Cancellation fee is up to full service price for appointments canceled with less than 24 hours notice. I take personal responsibility for this fee, and understand that insurance, if being billed, does not pay on my behalf.

Client Initials _____

Late Policy

If client is late, therapist will do his/her best to accommodate. However, in the event another appointment is scheduled immediately after, client will receive the scheduled time remaining, and will be responsible for payment of the full session amount. If the therapist is late, the client will receive the full scheduled time, or the remaining scheduled time will be pro-rated.

Client Initials _____

Insurance Reimbursement

If client has medical insurance and would like to discuss whether massage services are covered, please check here: Insurance companies recognized include, but are not limited to Workman’s Compensation, some personal injury, and ASHN affiliated policies. Please provide a copy of the insurance card.

Client Initials _____

Privacy Policy

Client understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. If you would like to have more detailed information about our policies and procedures concerning the privacy of your information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone that you do not want to receive your medical records, please inform our office. In the event the client is visiting any practitioners listed below, client initials indicate permission for those practitioners to discuss any and all pertinent health issues amongst themselves to the benefit of the client. Client may line out any professionals not approved for discussion of medical issues. This office does not release client information to any third parties. Dynamic Touch sends, from time to time, email and postal mail notices of seasonal promotions. If you would like NOT to receive any such notices, please check the “Opt Out” box on the other side.

List Permissible Practitioners (e.g., Personal Trainer, Physical Therapist, Chiropractor, Supervising MD)

Client Initials _____