ADVANCED THERAPEUTIC MASSAGE

Whole Body. Whole Life.

Welcome to Advanced Therapeutic Massage! Our priority is to make your appointment pleasant and comfortable. We welcome any questions or comments and appreciate the opportunity to work with you.

PLEASE PRINT CLEARLY

Name _____

Address _____

City _____ State _____ Zip Code _____

Birthday _____ Anniversary (if applicable) _____

Place of Employment _____ Occupation _____

Phone Numbers:

_____ Home ☐ Please checkmark

_____ Work ☐ preferred phone

_____ Mobile ☐ number.

How did you hear about Advanced Therapeutic Massage?

☐ Personal Referral – who may we thank for referring you? _____

☐ Internet (Google, Yahoo, Bing, etc.) - **please specify** _____

☐ Social Media (Facebook, Twitter, LinkedIn, etc.) – **please specify** _____

☐ Professional Referral – who may we thank for referring you? _____

☐ Drive-By ☐ Magazine - **please specify** _____

☐ Phone Book ☐ Newspaper - **please specify** _____

☐ Chamber of Commerce ☐ Other - **please specify** _____

E-mail address _____

We use e-mail addresses for appointment reminders, continuing education, and upcoming specials at Advanced Therapeutic Massage. Be assured that e-mail addresses will not be used for purposes other than enhanced communication between Advanced Therapeutic Massage and you.

What is your primary concern or complaint? _____

_____

Do you have other areas of pain or concern? _____

_____

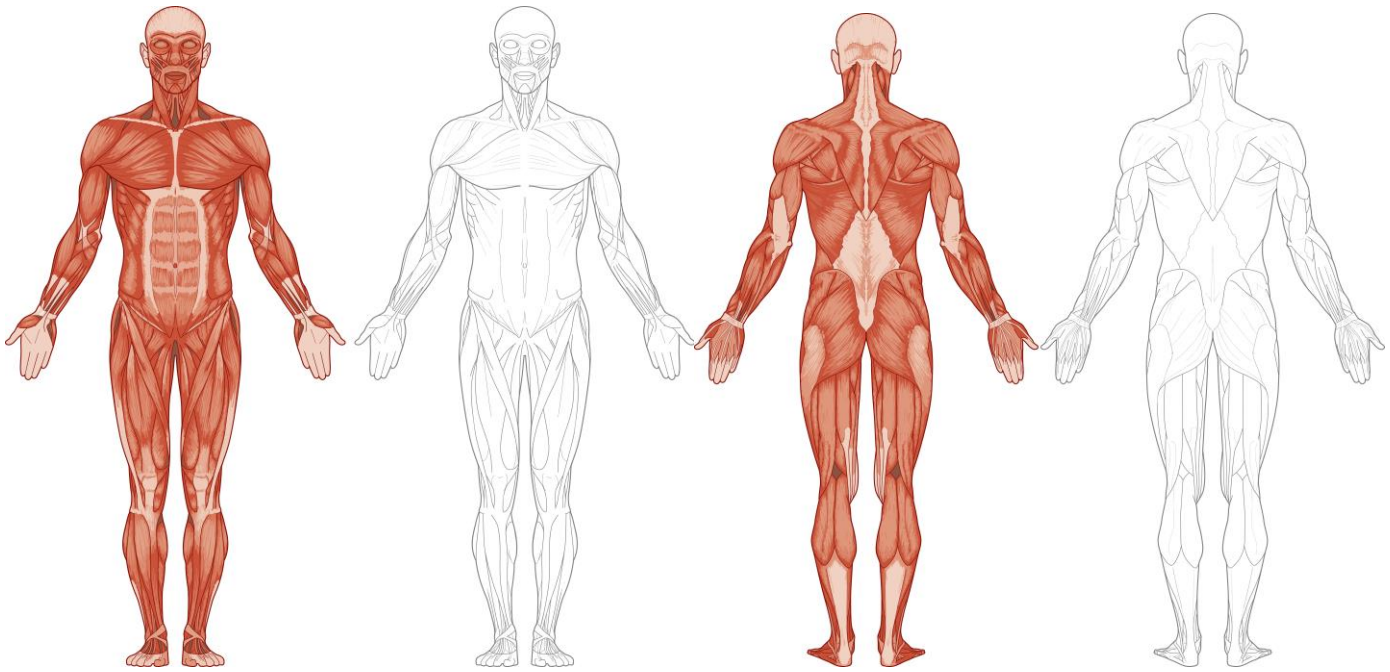
Please describe and date pertinent injuries and surgeries:

_____ _____

_____ _____

Please mark areas of concern:

front *back*



Do you have a history of the following:

☐ headaches	☐ sprains	☐ abdominal pain	☐ whiplash
☐ mid-back pain	☐ joint aches	☐ seizures	☐ allergies to lotions or oils
☐ low-back pain	☐ HIV	☐ high blood pressure	
☐ **n**eck pain	☐ stroke	☐ arthritis, bursitis or gout (please circle)	
☐ disk problem(s)	☐ heart attack	☐ breast augmentation	
☐ broken bones	☐ diabetes	☐ decreased range of motion	

Please list current medications:

_____

Do you have any of the following today:

- ☐ fever, cold, or flu
- ☐ infectious disease
- ☐ heart or kidney failure
- ☐ open cuts, bruises, burns, or skin conditions
- ☐ 0-14 weeks pregnant / 0-6 weeks postpartum
- ☐ surgery with the last 2 months
- ☐ accident within the last 6 months
- ☐ blood clots
- ☐ bleeding disorders

* *

We use a number of modalities during client sessions, based upon the needs and concerns of the client. These techniques may include, but are not limited to, neuromuscular therapy, sports/deep tissue massage, trigger point therapy, myofascial release, cranio-sacral therapy, and lymphatic drainage. Review of your medical history and your specific concerns will determine which modalities will be used and what areas will be addressed in your session.

If it is determined that breast massage is applicable, you will be asked to sign a consent form prior to this treatment. Your therapist will use draping at all times, unless it is determined that you will be clothed during your session.

Your concerns and comfort level are important to each of us. If at any time you become uncomfortable, please tell your therapist immediately.

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I understand that massage is not a replacement for medical care and no diagnosis will be made. I further understand that I am financially responsible for all services rendered at Advanced Therapeutic Massage and that all pre-paid services are transferrable but non-refundable. I agree to give 24 hours notice should I need to cancel or reschedule my appointment. I acknowledge that in the event that I no-show for two appointments, I may be required to pre-pay for my next service.

Client's Printed Name _____

Client's Signature _____ Date _____

Therapist's Signature _____ Date _____

We invite you to visit our website for additional information at www.wholebodywholelife.com.