



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 check  
\_\_\_\_\_ 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:

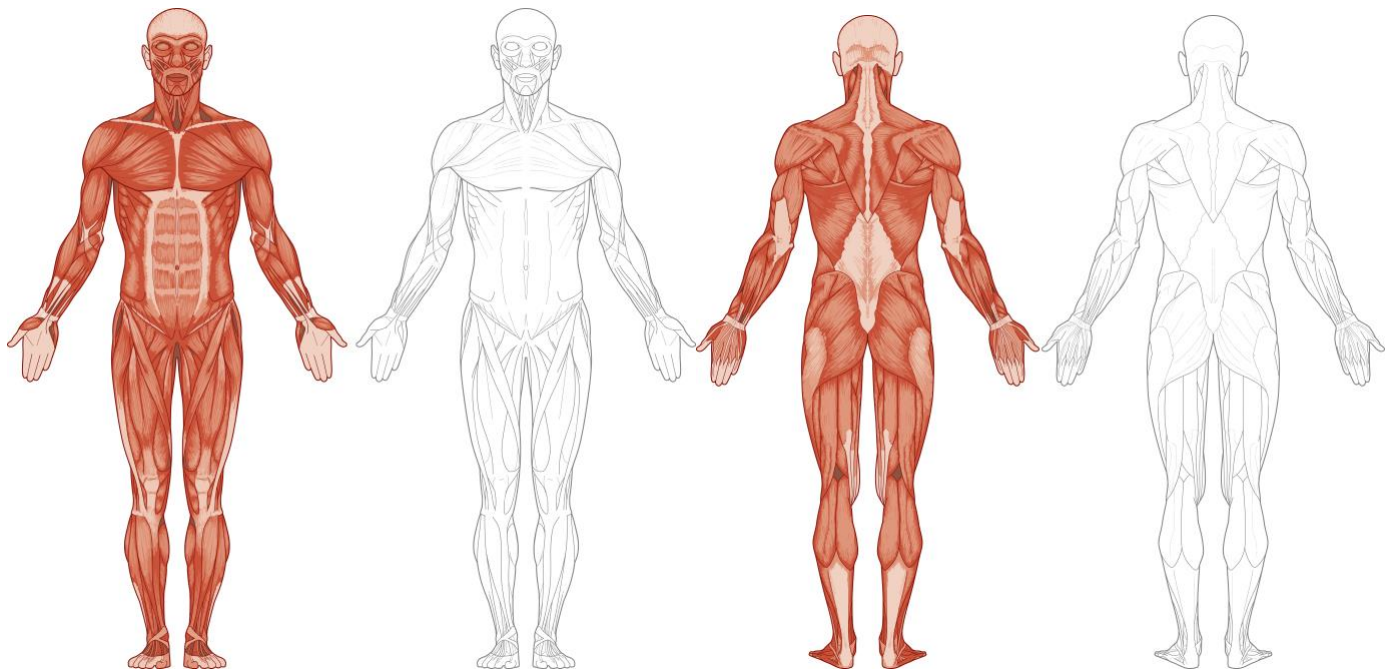
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had a massage before?      Yes      No

Please mark areas of concern:

*front*

*back*



Do you have a **history** of the following: (Please check all that apply.)

- |  |                                       |  |   |
|--|---------------------------------------|--|---|
| <input type="checkbox"/> headaches       | <input type="checkbox"/> sprains      | <input type="checkbox"/> abdominal pain                              | <input type="checkbox"/> whiplash                     |
| <input type="checkbox"/> mid-back pain   | <input type="checkbox"/> joint aches  | <input type="checkbox"/> seizures                                    | <input type="checkbox"/> allergies to lotions or oils |
| <input type="checkbox"/> low-back pain   | <input type="checkbox"/> HIV          | <input type="checkbox"/> high blood pressure                         | <input type="checkbox"/> blood clots                  |
| <input type="checkbox"/> neck pain       | <input type="checkbox"/> stroke       | <input type="checkbox"/> arthritis, bursitis or gout (please circle) |   |
| <input type="checkbox"/> disk problem(s) | <input type="checkbox"/> heart attack | <input type="checkbox"/> breast augmentation                         |   |
| <input type="checkbox"/> broken bones    | <input type="checkbox"/> diabetes     | <input type="checkbox"/> decreased range of motion                   |   |

Please list current medications:

\_\_\_\_\_

Do you have any of the following **today**:

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

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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](http://www.wholebodywholelife.com).