Donna Rowell & Associates~Licensed Massage Therapists

Client Information~ Please Print

Name:_____date of birth_____

Mailing Address: _____

City:_____State:_____ZIP_____e mail_____

Home Phone _____Work_____Cell_____

Age_____Occupation_____Employer_____

Referred by:_____

In Case of Emergency:_____Phone_____

0 Yes 0 No Have you had massage therapy before? If yes, what type of pressure do you prefer? Circle: Light, medium, deep.

0 Yes 0 No Do you experience frequent headaches? If yes how often and how intense?_____

0 Yes 0 No Are you pregnant? If yes, how far along?_____

0 Yes 0 No Are you currently being treated for cancer?

0 Yes 0 No Are you diabetic?

0 Yes 0 No Do you have high blood pressure?

0 Yes 0 No Do you have heart problems?

0 Yes 0 No Do you suffer seizure disorders or epilepsy?

0 Yes 0 No Do you have osteoporosis or broken any bones in the last 2 years?

0 Yes 0 No Do you have numbness or stabbing pains?

0 Yes 0 No Have you had recent surgery of any kind?

0 Yes 0 No Do you have any other medical condition that I should be aware of?

What would you like me to focus on today?

Office Policies

Lateness: If you are late, we can not make up your time. This would be unfair and disruptive to other patients/clients schedules.

If we are late, we will make up your time so that you receive your full treatment.

Cancellation: If you are unable to keep a scheduled appointment, please give 24 hours advance notice, to ensure that you will not be charged for the appointment.

If less than 24 hours notice is given and we are unable to fill you time slot, you will be expected to pay for the appointment.

Payment: Payment is expected at the time of service.

Insurance: You are responsible for payment of services. We will prepare the necessary paperwork and in some cases bill your insurance company. Any unpaid balance is to be paid by you.

We reserve the right to use our discretion to withhold treatment to any person.

Please Take A Moment To Carefully Read The Following Information And Sign Where Indicated. I understand that for specific medical conditions, massage may not be appropriate. I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist. I further understand that massage therapy is not a substitute for a medical examination, diagnosis, or treatment and that nothing said or done in the course of the session should be construed as such. I affirm that I have stated all my known medical

conditions and agree to keep the practitioner updated as to any changes in my medical profile and understand that there is 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 full payment of the scheduled appointment.

Signature_____

Date_____

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