Please Print Neatly! **ADVANCED MASSAGE THERAPIES CLIENT INFORMATION FORM**

Therapist: _____
Location: _____

Name_____Date_____/_____/_____

Address_____City_____State_____Zip_____

Phone (W) _____ (H) _____ (C) _____ E-mail_____

Male _____Female _____Date of Birth_____/_____/_____ Weight _____Height_____ Contact Lenses? ___Yes ___No

Marital Status: Single____Partner____ Your Employer _____ Occupation/Job Title _____

Emergency Contact Name/Relationship_____ Emergency Contact Number_____

Driver's License State: _____Number:_____ Exp: _____ Are you currently receiving medical or chiropractic care? ___Yes ___No

If you are receiving medical or chiropractic care, explain: _____

Name of physician(s) or therapist(s) _____

Are you taking any medications (prescription, over-the-counter, herbal)? ___Yes ___No If yes, please list:_____

_____

How did you hear about us? __Ad __Gift Cert. __Internet __Other _____ Referral (who?)_____

Are you currently contagious or feel like you might be coming down with a cold or flu? ___Yes ___No Recovering? ___Yes ___No

Have you ever experienced any of the following? *Please use **'C'** for current, **'P'** for past, **'S'** for sometimes. Leave blank if never.*

C P S Abdominal pain
C P S Acid reflux
C P S Adhesions or scarring
C P S AIDS/HIV
C P S Allergies
C P S Alzheimer's
C P S Amputation
C P S Anemia
C P S Aneurism
C P S Anxiety
C P S Arthritis
C P S Auto accident
C P S Back pain
C P S Blood clots
C P S Bone fractures
C P S Breathing problems
C P S Bursitis
C P S Burns
C P S Cancer
C P S Carpal tunnel
C P S Cellulitis
C P S Chronic fatigue
C P S Chronic pain
C P S Claustrophobia

C P S Circulatory problems
C P S Constipation
C P S Depression
C P S Diabetes
C P S Diverticulitis
C P S Epilepsy
C P S Fibromyalgia
C P S Foot pain
C P S Frozen shoulder
C P S Golfer's elbow
C P S Headaches
C P S Heart attack
C P S Heart problems
C P S Hematoma
C P S Hemophilia
C P S Hernia
C P S Herniated discs
C P S Hepatitis
C P S Herpes
C P S High blood pressure
C P S Hip pain
C P S Immune suppression
C P S Insomnia
C P S Irritable bowel
C P S Jaw/TMJ pain

C P S Joint pain
C P S Joint replacement
C P S Low blood pressure
C P S Lymphoedema
C P S Migraines
C P S Multiple sclerosis
C P S Muscle spasms
C P S Myofascial Pain Syndrome
C P S Neck pain
C P S Neuropathy
C P S Numbness
C P S Osteoporosis
C P S Palsy
C P S Panic attacks
C P S Paralysis
C P S Parkinson's
C P S Phlebitis
C P S Plantar fasciitis
C P S Postural problems
C P S Post traumatic stress
C P S Pressure sensitivity
C P S Psoriasis
C P S Rashes
C P S Raynaud's syndrome
C P S Rotator cuff injury

C P S Ringworm
C P S Sciatica
C P S Scleroderma
C P S Scoliosis
C P S Skin allergies
C P S Skin diseases
C P S Stiff neck
C P S Stress
C P S Sprains/strains
C P S Sports injury
C P S Surgery
C P S Stroke
C P S Swollen feet/legs
C P S Tendonitis
C P S Tennis elbow
C P S Tingling
C P S Tumors
C P S Varicose veins
C P S Whiplash
C P S Other _____
C P S Other _____
C P S Other _____
C P S Other _____
C P S Other _____
C P S Other _____

For Women Only:

C P S Amenorrhea
C P S Breast implants
C P S Breast pain
C P S Breast reduction
C P S Breast reconstruction
C P S C-section date___/____/___
C P S Endometriosis
Continued on Page 2.....

C P S Fibrocystic breasts
C P S Hysterectomy
C P S High risk pregnancy
C P S Infertility
C P S Inverted nipples
C P S Lumpectomy
C P S Mastectomy
C P S Menstrual cramps

C P S Menopause
C P S New mom birth date___/____/___
C P S Ovarian cysts
C P S PMS
C P S Pregnant due date___/____/___
C P S Urinary incontinence
C P S Urinary urgency/frequency
C P S Trying to be pregnant

Please Print Neatly! **ADVANCED MASSAGE THERAPIES CLIENT INFORMATION FORM**

 Name: _____ **Date:** _____

Accidents, Injuries, or Surgeries:
Less than 5 years ago (include dates)_____

_____

More than 5 years ago (include dates)_____

_____

Are you here for injury treatment? ___Yes ___No Date of Injury: _____/_____/_____ ___Auto ___Work ___Other

Please describe your current issue:_____

_____

_____

Date it began:_____ How did it begin? _____

_____

_____

What makes it better?

_____

What makes it worse?

_____

Any range of motion restrictions?

_____

What treatment(s) have you had for this condition? _____

_____

Rate your level of pain: No pain 1 2 3 4 5 6 7 8 9 10 unbearable pain

Describe your current pain/symptoms:
___Shooting ___Throbbing ___Dull ___Sharp/Stabbing
___Burning ___Numbness ___Soreness ___Tingling ___other_____

How often are your symptoms present?
___Constantly ___Frequently ___Occasionally ___Intermittently

Can you perform your daily ***home*** activities ___w/out pain ___w/pain

Explain _____

Can you perform your daily ***work*** activities ___w/out pain ___w/pain

Explain _____

How is the quality of your sleep? _____ Hours of sleep lost _____

Is there any swelling or tendency to swell anywhere in your body? _____

Are there any areas of inflammation? _____

Continued on page 3…

 Name: _____ **Date:** _____

Do you have any site restrictions due to:

____Area of infection
____Bone or spine metastasis
____Catheter
____Drains or dressings
____Fracture history
____History of blood clots or phlebitis
____Incisions
____I.V.
____Neuropathy
____Open wounds
____Other device
____Port
____Skin sensitivity
____Rash or skin condition
____Radiation
____Tumor site
____Ostomy
____Other_____

Do you have any pressure restriction due to:

____Anticoagulants
____Area of pain or burning
____Blood clots
____Bone or spine metastasis
____Fatigue
____Fragile/sensitive skin
____Fragile skin
____Infection or fever
____Low platelet count
____Lymph edema
____Recent surgery
____Steroid medication
____Varicose veins
____Other _____

Do you have any position restrictions due to:

____Claustrophobia
____Difficulty breathing
____Discomfort _____
____Dizziness
____Incision
____Medication
____Medical devices _____
____Nausea
____Ostomy
____Sinus issues
____Tender skin
____Tumor site

Has your medical condition or medical treatment affected any of the following functions in your body?

____Balance
____Breathing
____Blood counts
____Energy level
____Heart
____Kidney
____Liver
____Lungs
____Memory
____Nervous system
____Range of motion
____Other_____

For Cancer Patients Only:

When were you first diagnosed with cancer? _____ What type(s)? _____

Where was/is it located? _____

Are you being treated now? _____

What treatments have you had and when? _____

Did your treatment include any removal or radiation of lymph nodes? If yes, how many and where?_____

_____

Did your treatment include radiation therapy? If yes, where and what type?_____

_____

How is your energy level and sleep? _____

Have you had issues with lymphedema? _____

Have you tried any treatment for it? _____

Notes: _____

_____

_____

_____

Continued on page 4…

 Name: _____ **Date:** _____

	Heavy	Moderate	Light	None
Tobacco	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Exercise	_____	_____	_____	_____

What type(s) of exercise? _____

_____

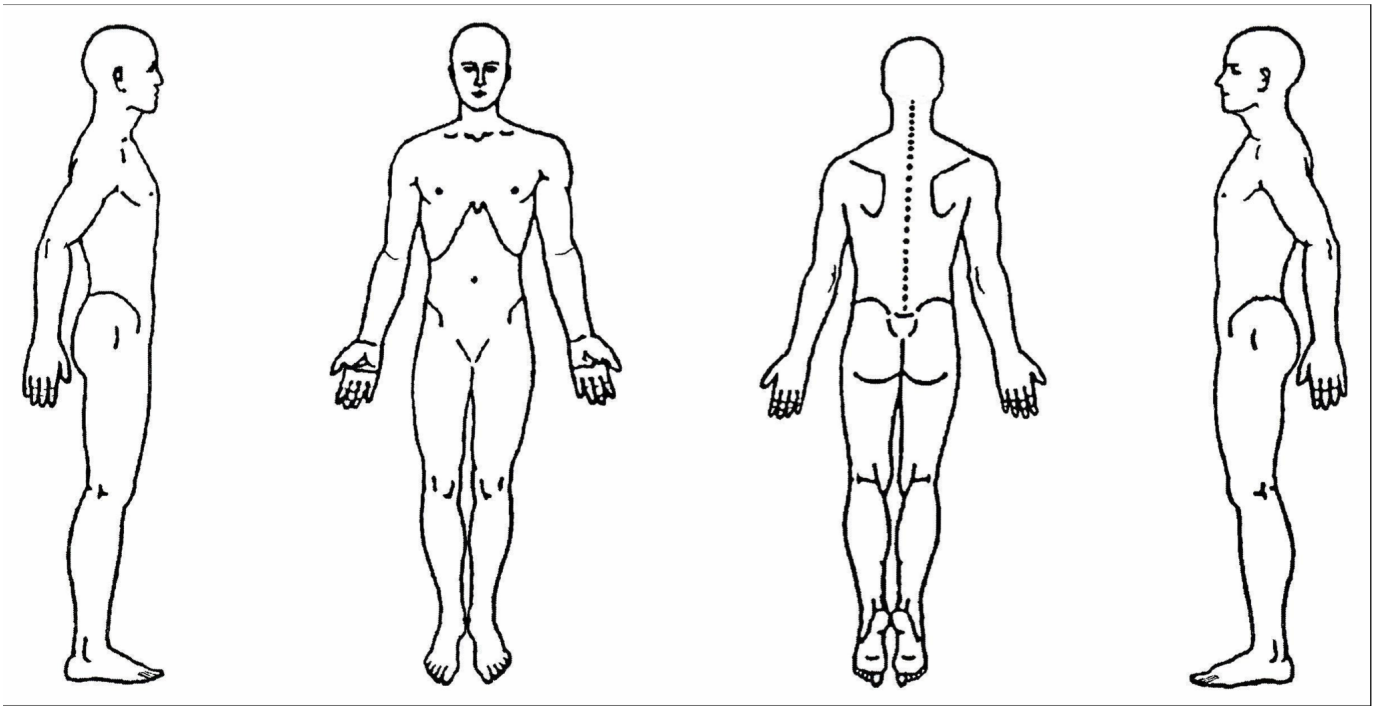
How often?_____

- Have you ever had massage / bodywork before? Yes___ No___ When?_____ Frequency?_____
- What did you especially like or dislike? _____
- Why have you come for massage therapy? _____
- What are your goals with massage therapy? _____

_____

1. How do you feel right now (physically, emotionally, mentally)? _____

Mark on the pictures where you have symptoms: Pain **X** Numbness **+** Tingling *****
Circle areas you do not want to be touched; genitals are never touched.



Notes: _____

_____

_____

_____

_____

Continued on page 5…

 Name: _____ **Date:** _____

PLEASE TAKE A MOMENT TO CAREFULLY READ THE FOLLOWING INFORMATION AND SIGN WHERE INDICATED TO SHOW THAT YOU HAVE READ, UNDERSTAND, AGREE, AND CONSENT TO OUR POLICIES.

Consent for Therapy:

- If I experience any pain or discomfort during any session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort. Also, I will immediately notify my therapist should I have any questions or concerns following therapy.
- I further understand that massage / bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage / bodywork therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.
- Because massage / bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I neglect 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 responsible for full payment of the scheduled appointment. If necessary, local law enforcement will be called.
- I agree to the release of information and records for medical and / or insurance purposes and authorize Advanced Massage Therapies, Inc. to obtain and/or release any information to / from my healthcare providers concerning my health.
- If my employer has sent me for treatment, I authorize Advanced Massage Therapies, Inc. to obtain and/or release any information to/from my employer concerning my health.
- I understand that I may have cupping on my body. Temporary bruising or redness ("hickies") lasting a few days is a common side effect of cupping. Other side effects may include, but are not limited to: pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. Post treatment, I should not expose the area to hot or cold temperatures or engage in heavy exercise.
- Audio, video, and photographic recordings may be made to mark the progress of my therapy (before and after for postural changes, etc.) and with facials (before and after for wrinkle reduction), or testimonials, may be used for educational purposes and promotion of Advanced Massage Therapies, Inc. I understand that I will be given advanced notification of such recordings, and I have the right to refuse at any time or keep such recordings private and unpublished. This does not mean that such recordings will be done, but should they ever, we have your permission on file.
- I understand that certain conditions and medications may be contraindicated for certain therapies. They include, but are not limited to: bleeding disorders, use of anticoagulants, medical implants, incisions, open wounds, drains, or dressings, skin sensitivity, rash, or other skin conditions, inflammation, risk of infection, etc. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I neglect to do so.
- If I have a specific medical condition or specific symptoms, massage / bodywork may be contraindicated. A referral from my primary care provider may be required.
- I do not have any contagious disease, nor have I been exposed to anyone who is contagious or symptomatic within the past 14 days.
- I have not visited any location known to be a "hot spot" for any contagious disease in the past 30 days.
- I understand that this business and my massage therapist cannot be held liable for any exposure to any contagion caused by misinformation on this form or the health history provided by me.
- By signing below I agree to release the massage therapist and business from any and all liability for the unintentional exposure or harm due to COVID-19 or any other infectious/contagious disease.

For Women Only: Consent for Breast Therapy:

- This does not mean that you will have this therapy done, but should we ever have the need to do this therapy, we have your permission on file.
- I understand that breast therapy may be done with my advanced notification and permission if indicated. It is indicated for, but not limited to: the treatment of scarring, pain, and dysfunction of the breast, chest, back, shoulder, neck, and head areas. If I experience any pain or discomfort during any session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort. Also, I will immediately notify my therapist should I have any questions or concerns with the therapy.
- I understand that certain conditions, medications, and treatments (radiation, chemotherapy, etc.) or may be contraindicated for this therapy. They include, but are not limited to: medical implants, incisions, open wounds, drains, or dressings, skin sensitivity, rash, inflammation, risk of infection, etc. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I neglect to do so. Also, I understand that breast work not sexual in nature. I understand that I may refuse or terminate this therapy at any time.

I have read, understand, and agree to the above following policies, and I consent for therapy at Advanced Massage Therapies, Inc.

☞ **Client or guardian signature: _____Date: _____**

☞ **Signature of person responsible for payment if different from above:**

_____Date: _____

Continued on page 6…

 Name: _____ **Date:** _____

New Client Information

- Please save time by downloading, printing, and filling out the New Client Forms and bring them with you on your first visit. If you are unable to print out the forms, please call to let us know in advance (so we know to expect you) and plan to arrive at least 20 minutes prior to your scheduled appointment time in order to fill it out in our office.
- If you do not arrive early, the time taken to fill out your forms is included within your scheduled appointment time, and will therefore result in a shortened appointment.
- Completion of the New Client Forms is required for all clients, and we will not perform services without a full health intake.
- We endeavor to provide a caring and relaxing environment for your massage experience. We ask that clients' voices be kept at a quiet level. Please silence your phone upon arrival by turning it off or on do not disturb mode. If you need to be available take a call during your session, please let your therapist know, and put your phone on vibrate.
- Out of respect for your therapist and others who may be following you, please refrain from wearing perfume or smoking before your appointment. We ask that you be clean and free from strong odors such as perfume, smoke, or body odor. Clients with strong scents may be refused service and will be responsible for payment in full for the appointment.

Payment

- Payment for services is required at time of scheduling, and is non-refundable. Payment is assigned to an individual client's account, and is not transferable to another client.
- We accept all major credit cards, cash, and in-state checks with a valid driver's license matching the address on the check. We also accept Health Savings Account (HSA) and Flexible Spending Account (FSA) cards.
- Each bank returned check will be charged $30.00. Additional court, attorney, or collection agency fees may be charged if applicable.

Scheduling

- Please call 770-834-4599 to schedule.
- All clients are required to pay in full at time of scheduling for appointments, and it is non-refundable.

Appointments, Cancellation, & Rescheduling

- Appointments are an agreement to reserve a portion of available office time. Please arrive a few minutes early. We cannot guarantee full service time for late arrivals, and you will be responsible for the full amount of your session. Upon arrival, if you request a shortened service, you are responsible for the full amount of the scheduled service. Your session time includes consultation, assessment, treatment, dressing time, and check in/check out.
- All appointments require payment in full at time of scheduling and are non refundable. If multiple sessions (not part of a program) are scheduled, we only require that clients pay up front for one appointment at time. When you come for an appointment, your next one is paid for on that day.
- There are no refunds given for canceled or missed appointments.
- Programs: The full amount of the program must be paid in full at time of scheduling. Clients who have pre-paid for programs will have the full amount of the missed appointment deducted.
- Appointments may be rescheduled once with a minimum of 7 days' notice. If a client needs to reschedule more than once, a fee of 50% the value of the appointment will be charged for the rescheduling. Rescheduling must be within six weeks of the original appointment, otherwise it is considered a cancellation, and the full fee for the new appointment must be prepaid. Rescheduling for 1/2 day (3-4 hours service) require a minimum of 10 business days' notice, and full day services (any time over 4 hours) require 15 business days' notice for rescheduling.

Appointment Confirmations

- Texts: Confirmations are automated texts sent by the computer which accepts only "yes" or "no" for a response. Please do not respond with any other message or an abbreviated "y" or "n". Any response other than "yes" or "no" is not accepted by the system. Your appointment will change color on the computer screen to indicate confirmation or cancellation; responses are not read by a human. Any additional information cannot be received via text.
- Emails: All emails are generated by the computer system in an unmonitored mailbox. Replies cannot be received.
- You are responsible for keeping your appointment. Please set your own reminders. If the system should go down (power outage or loss of internet, etc.) reminders will not go out.
- If you need to communicate, please call the office at 770-834-4599. Do not text or email.

 Name: _____ **Date:** _____

Children

- Children receiving treatment: Children under the age of 18 are required to have a parent or guardian sign the health intake form and be present for the first appointment. We prefer that the parent or guardian be present in the treatment room during all sessions for education on the child's therapy.

- Clients who wish to bring children along for their session: Children must be well behaved and be able to quietly self entertain during your session. Please no food or drinks, as spills and messes often occur. We have bottled water available. For younger children, please make arrangements for child care.

Health Insurance

- Some health insurances cover for medical massage therapy. Advanced Massage Therapies, Inc. does not bill insurance directly. If your insurance provider covers for therapy, payment in full is expected at the time of scheduling, and it is your responsibility to file with your insurance for reimbursement.

- For additional information, refer to the Insurance Form.

Gift Certificates

- Gift certificates sales are final, and no refunds are given. They are not redeemable for cash.

- Expiration dates are final, so please schedule your appointment well in advance of the expiration date.

- If the gift certificate holder would like to exchange for another service, the gift certificate will be exchanged for the dollar amount paid and put toward another service.

- The gift certificate number is required at time of scheduling to secure the appointment.

- Gift certificates must be presented at time of service.

- Missed appointments or cancellations less than 7 days in advance will have the full amount of the service deducted from the gift certificate.

Corporate Accounts

- Missed appointments or cancellations less than 7 days in advance will be billed for the full fee. Balance is due 30 days from the invoice date. A $50.00 re-billing fee plus 10% interest will be charged each month until balance due is paid.

I have read, understand, and agree to the above following policies, and I consent for therapy at Advanced Massage Therapies, Inc.

☞ **Client or guardian signature: _____Date: _____**

☞ **Signature of person responsible for payment if different from above:**

_____Date: _____