Health Information

Client Information

Name _____ Date _____ Referred By _____

Address _____ Birth date _____

Phone _____ cell ☐ landline ☐

Preferred method of contact for a follow up: text ☐ call ☐ Best time to reach you: _____

I give my permission for you to leave any information for me, and to use your name/clinic name, at the phone numbers listed above. _____ **Please Intitial**

Would you like to receive emails from Hands of Grace regarding current promotions? Yes ☐ No ☐

(Your email address will not be sold or shared.) **Email**: _____

Occupation _____ For How Long _____

Emergency Contact Name / Phone _____

Client Agreement

Please take a moment to read the following. Sign and date where indicated.

- I understand that the information I give on this form is confidential, and will be used for no other purpose than treatment protocol and the therapist's clinical studies.
- I understand that the massage/bodywork I receive is provided for the therapeutic purposes. If I experience any pain or discomfort during my sessions, I agree to inform the therapist immediately so that the pressure and/or technique may be adjusted to my level of comfort.
- Because massage/bodywork is contraindicated under certain health conditions, I affirm that I have disclosed all known health conditions and answered all questions honestly. I agree to keep the therapist updated as to changes in my health and my use of pharmaceuticals, and agree that there shall be no liability on the therapist's part should I not do so.
- It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care and that information provided to me is educational in intent and not diagnostically prescriptive in nature.
- It is understood that the services I receive are strictly therapeutic and non-sexual in intent or practice.

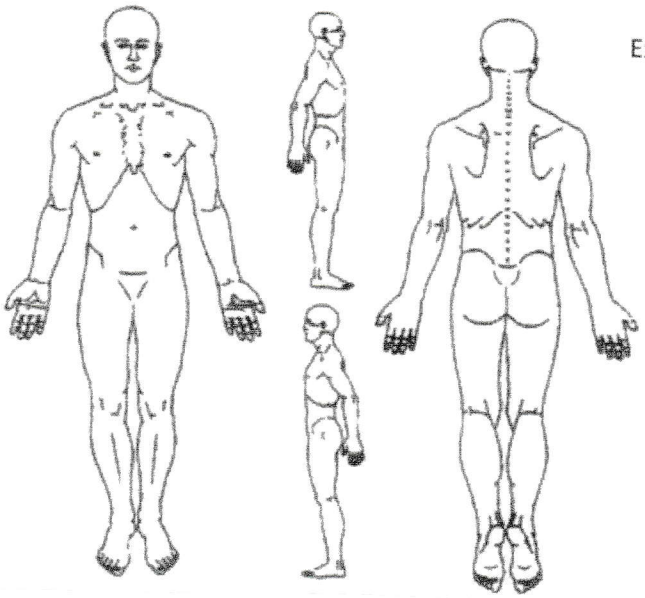
I have read and understand the Notice of Privacy Practices for Protected Health Information, which is posted on the wall of the client waiting area, and I agree to these policies and procedures. **Please initial _____.**

I understand that I am financially responsible for my appointments, and payment is due at the time of service, unless otherwise arranged in advance. **In order to avoid charges, I agree to give 24 hour notice of cancellation. Please initial _____.**

_____

Client Signature Date

Please Mark areas of discomfort: How would you grade your discomfort?



Excruciating	10
	9
	8
	7
	6
Moderate	5
	4
	3
	2
	2
	1
None	0

Therapist Notes:

When did the discomfort start? _____

What movement or action aggravates the area? _____

_____

Are you currently seeing a medical practitioner / chiropractor? _____ Have you received a diagnosis? _____
Please explain _____

Have you received professional massage/bodywork before? _____When_____

What type of pressure do you like / dislike? _____

Do you have or have you had any of the following? (Please check all that apply)

___ High Blood Pressure
___ Phlebitis/Varicose Veins
___ Heart Condition
___ Any Contagious Disease
___ Diabetes
___ Osteoporosis
___ Arthritis/Tendonitis
___ Bursitis
___ Lupus
___ Athletes Foot/Warts
___ Epilepsy
___ Insomnia
___ Headaches/Migraines
___ Shingles
___ Currently Pregnant
___ Depression
___ Numbness/Tingling
___ Broken Bones
___ IBS, Diverticulitis

Operations _____
Accidents _____
Allergies _____
Current Medications / Supplements _____
Health Maintenance, i.e. exercise / diet _____

Are you wearing contacts? Yes ◯ No ◯
Are you wearing a hairpiece? Yes ◯ No ◯

Practitioner Name: _____