FIFTH AVE. MASSAGE

Wellness Form

Date_____/ _____/ _____

Personal Information

Name_____ Phone_____

Address_____ City/State/Zip_____

Occupation _____ DOB_____

Email_____ Primary Physician _____

Emergency Contact_____ Relationship_____ Phone_____

How did you hear about us?_____ Referred by_____

Date of Injury _____ Doctor_____ Phone _____

Insurance Co. _____ Phone _____ Contact Name _____

Medical Information

Are you taking any medications? ☐yes ☐no

If yes, please list name and use: _____

_____

Do you suffer from chronic pain? ☐yes ☐no

If yes, please explain _____

Acute inflamation _____

Low back/Disk problems _____

Have you had any orthopedic injuries? ☐yes ☐no

If yes, please list: _____

_____

Broken bones? ☐yes ☐no

If yes, when: _____

_____

Are you currently under medical or PT supervision?

☐yes ☐no Condition? _____

Any other medical information of which we should be aware? _____

_____

Please indicate any condition you have had in the past or currently have.

☐Have you ever had a massage before

☐Arthrisis/Buursitis/Osteoporosis	☐Stroke
☐Varicose Veins	☐Scoliosis
☐Eczema	☐Pregnancy
☐Plantar Warts/Foot Fungus	☐HIV + or Hepatitis
☐Heart Condition/Pacemaker	☐Medications
☐Headaches/Dizziness	☐Open Wound
☐Cancer	☐Neuropathy
☐Headaches/Migraines	☐Fibromyalgia
☐Exercise	☐Heart Attack
☐Diabetes	☐Blood Clots
☐Joint Replacement(s)	☐Numbness
☐High/Low Blood Pressure	☐Sprains or Stains

☐Are you wearing contact lenses? ☐yes ☐no

☐Recent or Any Surgery_____

_____

☐Other _____

Explain any conditions you have marked above:

_____

_____

Massage Information

Have you had a professional massage before? ☐yes ☐no

What type of massage are you seeking?

☐Relaxation ☐Therapeutic/Deep Tissue

Other _____

_____

What pressure do you prefer?

☐Light ☐Medium ☐Deep

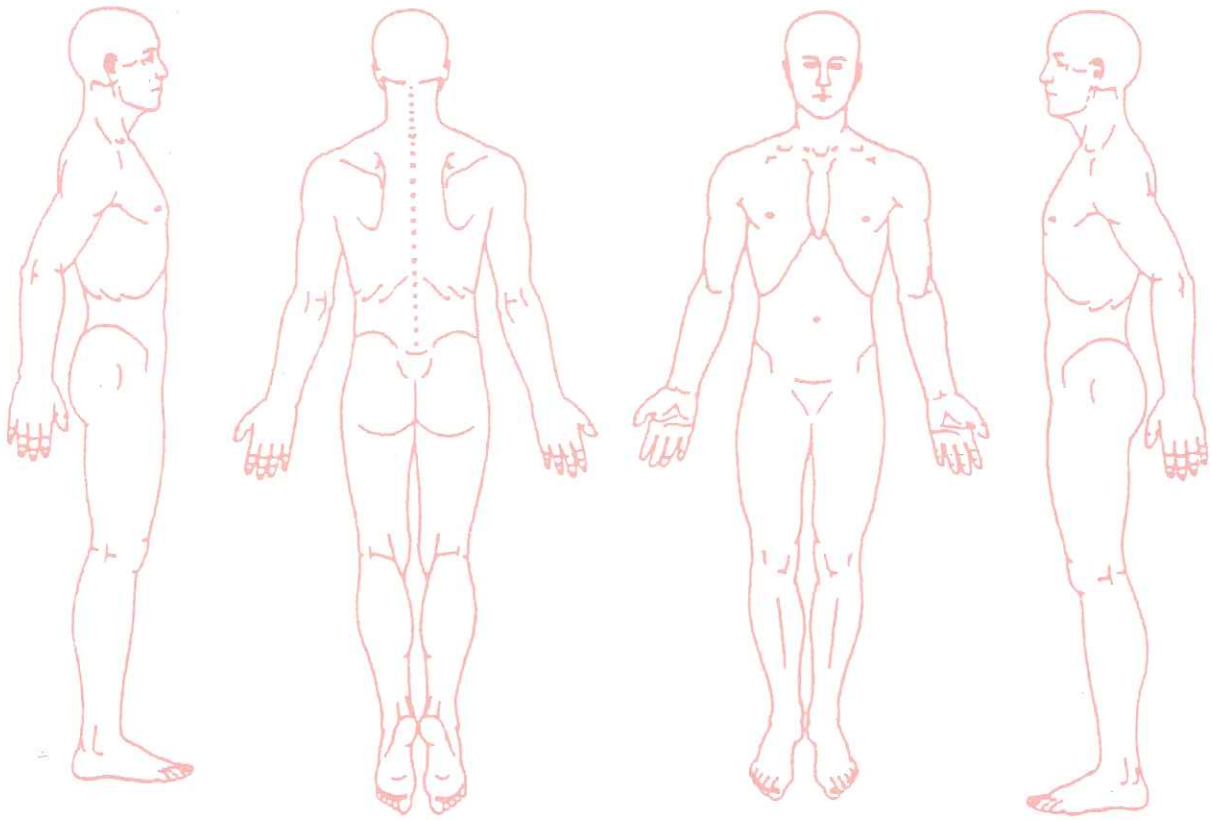
Are you sensitive to any fragrances/allergies? ☐yes ☐no

What are your goals for this treatment session?

_____

_____

Please circle any areas of discomfort



Massage Therapy Informed Consent

I understand that massage therapy provided by FIFTH AVE. MASSAGE, is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulations and offer a positive experience of touch.

The general benefits of massage, possible massage contraindication and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

Client Signature _____ Date _____

CANCELLATION POLICY

Out of respect to your therapist and other clients, we request the right to ask for 24. hour notice if you need to cancel your appointment with a therapist here at FIFTH AVE. MASSAGE. FIRST time you miss we respectfully ask for $25.00 of you total appointment. SECOND time, it will be the full amount of your appointment scheduled. Any misunderstandings or unforeseen emergencies will be considered and discussed. Your time is precious and very important to us, and we will work hard to meet the high standards of promptness and accountability. We respectfully ask the same of you.

Office Int. _____ –Therapist of Fifth Ave. Massage