TY _____ SURVEY _____ REFERRAL TY_____ BOOKINGTIMES_____ UPDATED_____

VITAL LIVING *WellSpa* – Confidential Client Information

FAX#: (260) 436-2767

Name_____ ***How did you hear about us?*** _____
Example: sign, web search, gift card or referral (list name), etc..

Address_____
City *State* *Zip*

Date of Birth_____ **Workplace**_____ **What do you do?** _____

Cell Phone(____)_____ **Home Phone**(____)_____ **Work Phone**(___)_____

Age____ **Male**___ **Female**___ **Other** ___ ***Email Address***_____

HELP US UNDERSTAND YOUR EXPECTATIONS AND GOALS

Is *pain or stress limiting your normal daily activities?* Yes No

How *important do you feel massage therapy is in your health maintenance program?* Scale of 1–10_____

Do *you see this visit as:*

_____ part of a treatment plan _____something you'd like to do occasionally *(how often_____)* _____a treat

Do you have an HSA? _____ *Do you need a receipt for insurance reimbursement?* _____

Your Current or Past History:

Yes No Frequent headaches?
Yes No Diabetes?
Yes No Are you pregnant?
Yes No # of natural births____ C-sect____
Yes No Abdominal, pelvic, or GI discomfort?
Yes No Varicose veins?
Yes No High blood pressure?
Yes No Seizure disorder?
Yes No Any surgeries? *See back page*
Yes No Bruise easily?
Yes No Smoker? How much? _____
Yes No Alcohol? How much/how often _____

Yes No Any accidents or injuries - ever?
Yes No Broken bones - ever?
Yes No TMJ symptoms?
Yes No Are you sensitive to touch or pressure?
Where? _____
Yes No Cancer? Where?_____ When _____
Yes No Heart or circulatory problems?
Yes No History of blood clots or taking blood thinners?
Yes No Allergies? Asthma?
Yes No Osteoporosis?
Yes No Sensitivity to: Gluten _____ Nuts _____
Essential Oils (list) _____

COMMENTS: *Other pertinent health history; list medications:* _____

Please take a moment to carefully read the following information & sign where indicated.

If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. You understand that the massage/bodywork you receive is provided for the basic purpose of relaxation, relief of muscular tension and release of soft tissue restrictions. If you experience any pain or discomfort during the session, you will immediately inform the practitioner so that the pressure may be adjusted to your level of comfort. You further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, treatment & that you should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that you are aware of. You understand that massage/bodywork practitioners 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 should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, you affirm that you have stated all your known medical conditions, and answered all questions honestly. You agree to keep the practitioner updated as to any changes in your medical profile & understand that there shall be no liability on the practitioner's part should you omit or 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 dismissal as a client. Law enforcement may be called. Full payment is expected.

READ and INITIAL _____

- A CREDIT CARD WILL BE SECURED FOR ALL APPOINTMENTS.
- LATE ARRIVAL – payment will be due for the full amount for which the appointment was reserved.
- RESCHEDULING/CANCELLATION POLICY FOR APPTS ≤ 90 MIN – a minimum of **24 hours** is required to avoid a $25 fee.
- RESCHEDULING/CANCELLATION POLICY FOR A PARTY OF 2 OR MORE PEOPLE, SPA DAY PACKAGES OR APPTS >90 MIN – a minimum of **48 hours** is required to avoid a $25 fee per person or $25 fee per hour of reserved appointment time.
- NO SHOWS/MISSED APPOINTMENTS – A $25 fee will be charged and all future appointments must be pre-paid. If absence is due to an emergency, communication with the Front Desk is vital for fee not to occur.

HIPAA – Authorization to disclose information to (list all names): _____

CLIENT SIGNATURE_____ **DATE**_____

Signature of Parent or Guardian_____ **DATE**_____

Emergency Contact & phone #_____