Massage Paperwork

Date: _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Wireless Provider (for confirmations): _____

Do we need to be discreet with messages? **Y** **N**

Email Address: _____

How did you hear about us? _____

Employment Information

Company Name: _____

Company Address: _____

Company Telephone Number: _____

Emergency Contact Information

Name: _____

Relation: _____

Phone: _____

Primary Physician Name: _____

Primary Physician Address: _____

Massage Information

Have you ever received a massage before? **Y** or **N**

What kind of pressure do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving a massage?

(Example: To relieve stress, pain, stiffness, numbness/tingling, swelling, etc.)

_____
_____
_____

How do you feel today? _____

Do these symptoms interfere with your activities of daily living? **Y** or **N**

If yes, explain:

_____
_____
_____

List the medications you currently take:

_____
_____
_____

Are you wearing contacts? **Y** or **N**

Are you wearing dentures? **Y** or **N**

Are you wearing a hair piece? **Y** or **N**

Are you pregnant? **Y** or **N**

If so, how far along are you? _____

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?

_____

Circle any of the following health conditions that you currently have:

Blood Clots Infections Congestive Heart Failure Contagious Diseases Pilled Edema

Please indicate conditions that you have or have had in the past.

Explain in detail, including treatment received:

Current Past Muscle or joint pain: _____

Current Past Muscle or joint stiffness: _____

Current Past Numbness or tingling: _____

Current Past Swelling: _____

Current Past Bruise easily: _____

Current Past Sensitive to touch/pressure: _____

Current Past High/low blood pressure: _____

Current Past Stroke and/or heart attack: _____

Current Past Varicose veins: _____

Current Past Shortness of breath, asthma: _____

Current Past Cancer: _____

Current Past Neurological (MS, Parkinson's, chronic pain) _____

Current Past Epilepsy, seizures: _____

Current Past Headaches, migraines: _____

Current Past Dizziness, ringing in the ears: _____

Current Past Digestive Conditions (Crohn's, IBS): _____

Current Past Gas, bloating, constipation: _____

Current Past Kidney disease, infection: _____

Current Past Arthritis: _____

Current Past Osteoporosis, degenerative spine: _____

Current Past Scoliosis: _____

Current Past Broken bones: _____

Current Past Allergies: _____

Current Past Diabetes: _____

Current Past Endocrine/thyroid conditions: _____

Current Past Depression/anxiety: _____

Current Past Memory loss, confusion: _____

Any other health conditions that are not listed? _____

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/body work should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/body work 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 given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all of my medical conditions and answered all questions honestly.

I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand 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 payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: _____ **Date:** _____

Parent or Guardian Signature: _____ **Date:** _____

Refund Policy

BodyRx offers NO refunds or exchanges on any products or services.

Financial Policy

All services require payment prior to services being rendered. Insure you have correctly answered the prescreen questions if you are a weight loss client to avoid paying for a service you do not qualify for.

NO CHECKS, NO HEALTH SAVINGS ACCOUNT, NO FLEXIBLE SPENDING ACCOUNTS

Tardiness

Appointment times for massage are as scheduled and cannot extend beyond the stated tie to accommodate late arrivals. Please be on time for your appointment.

If arrival is delayed for spa services, we will make every effort to accommodate your appointment, but this is not always possible. Service time may be abbreviated to avoid delays for other guests as treatments are charged at the full value. Appointments missed by 15 minutes or more are cancelled with a 100% spa credit for the treatment amount missed, which is yours to use once your treatment is rescheduled.

Sickness

Massage/Bodywork is not appropriate care for infectious or contagious illness. Please cancel or reschedule your appointment as soon as you are aware of an illness.

Cancellation Policy

BodyRx Louisville enforces a **24-hour cancellation policy** for *ALL* appointments.

In order to reschedule your appointment, you must notify BodyRx at (502)882-8680/(502) 974-3447 **24 hours** before your scheduled appointment time to avoid being charged a **$35 cancellation/no show fee**. If you fail to show up to the scheduled appointment or cancel within 24 hours, we are hereby authorized to initiate entries to the debit/credit card account that is on file. If you do not have a card saved on file, please understand that you will receive a bill and that the fee must be paid prior to scheduling another appointment.

_____ _____

Signature Date