GEORGIA MEDICAL MASSAGE
CLIENT INFORMATION

Name: _____ Date of Birth: _____/_____/_____

Address: _____City: _____State:_____ Zip: _____

WK PHONE: ( ) _____-_____ HM: ( ) _____-_____ CELL: ( ) _____-_____

Emergency Contact and their phone number: _____ ( )_____-_____

Employer _____Type of work: Desk Standing Manual

Join Our Email List: _____

Have you ever posted a review on Yelp.com? Yes No

Referred by? (Circle) Sign Internet Yellow Pages Madison Friend Charity Event

Coupon Doctor or other professional - who? _____ Other_____

Check all that apply:

- □ Blood clots
- □ Cancer
- □ Diabetes
- □ Fibromyalgia/Lupus
- □ Headaches
- □ Heart Problems
- □ High/low blood pressure
- □ History of Strokes
- □ Immune system deficiencies
- □ Infections
- □ Insomnia
- □ Osteoarthritis
- □ Osteoporosis
- □ Menstrual pain (high)
- □ Pain (joint, muscle, disc, nerve)
- □ Rheumatoid arthritis
- □ Thyroid issues
- □ Varicose Veins
- □ Seizures/Convulsions

How often have you received massage in the last 12 months? (Circle) None 1-4 5 or more

Why a massage today? Relaxation Pain Relief Self-Care Education Other _____

List any injured areas to stay away from: _____

Are you currently suffering from any pain related to traumatic experience (i.e.: car accidents, sports injuries, surgeries, etc.)? **Y / N** If yes, briefly explain what: _____

_____ When? _____

If you are currently taking any medications or supplements please list below & on back of sheet:

_____

Do you have any conditions that may require a doctor's note? **Y / N** _____

For women, are you pregnant? **Y / N** If yes, how far along are you? _____

Do you have a Health Savings or Flexible Spending Account? Y / N

I will inform my therapist before sessions of any changes that have occurred in my health. I understand that my personal and medical information is confidential and will not be shared with anyone without my permission. I understand that information given to me by my therapist is educational in nature and is to be used to promote my own health at my own discretion. My therapist may recommend that I seek appropriate medical attention for any disease or condition observed during the practice of Massage Therapy.

PAYMENT

I agree to pay for all services of my therapist at the time they are rendered, unless prior arrangements have been made. If I fail to re-schedule my appointment 24 hrs before I understand my responsibility to pay 50% of the regular cost or minimum charge of $20. **No show - No call results in 100% payment.**

Signature: Date: