Whole Health Center
Massage Therapy

Name:_____ Date:_____ Occupation:_____

Have you had a massage before? _____ Did you enjoy your last massage? _____

Purpose of this massage: _____

Are you pregnant? _____ If yes, how many months? _____

What questions or concerns or special needs do you have? _____

Medical History: (Please Check all that apply)

- ☐ Allergies
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Multiple Sclerosis
- ☐ Pace Maker
- ☐ Seizures
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Other: _____

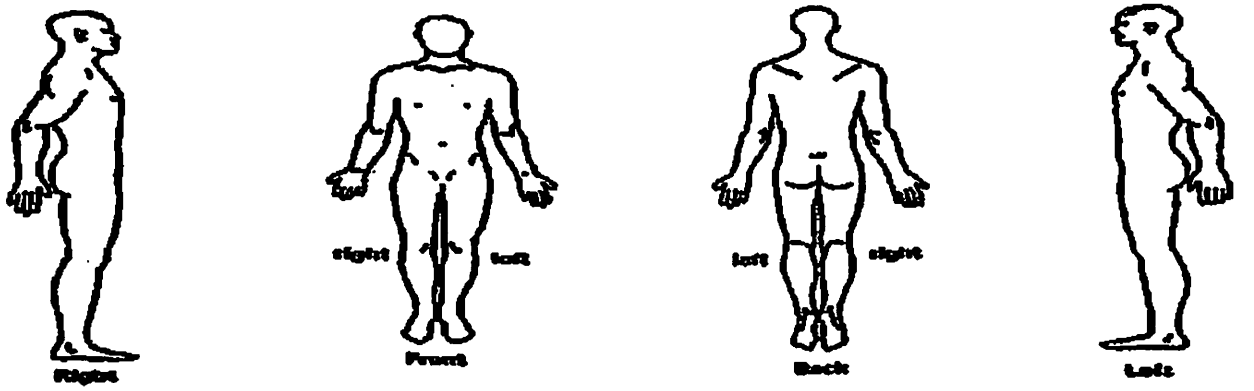
Surgical History:

1. _____ Year:_____ 2. _____ Year:_____

Medications: _____

_____

Please mark ALL areas of pain or discomfort:



If you require medical records for an insurance claim, please make this request to your practitioner upon your initial visit.

Date of Request: _____ Initials: _____

Given the strict adherence to massage therapy being a non-sexual service, clients may remove all or part of their clothing (depending on their comfort level) to improve the therapeutic value of the massage. If you have any questions of concerns about this topic, please discuss these concerns with your massage therapist. If you have a specific medical condition or specific symptoms, massage may be contraindicated. A referral may be required prior to service being provided.

I understand that massage therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician, chiropractor, or other qualified specialist for any suspected ailments. I understand that nothing said during the course of a session should be construed as diagnosis or prescription. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly.

I agree to keep the practitioner updated as to any changes and understand that there shall be no liability on the practitioner's part should I forget to do so. I also understand that all information provided on this form or given verbally while in session is strictly confidential other than as required for insurance billing purposes or required by law. Any other release of this information cannot be granted without written consent.

By signing below, I acknowledge that I fully understand and agree to the above information.

Signature: _____ Date: _____

(Signature of patient or legal guardian)

Print Name: _____

WELCOME TO WHOLE HEALTH CENTER
CONTACT INFORMATION

First Name: _____ Last Name: _____

Address:_____

City, State, ZIP:_____

Patient Sex: ☐ Male ☐ Female **Date of Birth:** _____

Telephone: Home_____Cell_____Work _____

Do we have your permission to send appointment reminders and clinic updates to your email address? Yes _____ No _____ We will not sell or give your email to any other agency.

Email Address:_____

Emergency Contact: Name_____

Telephone_____Relationship_____

How did you hear about us?

☐ Friend or Family (name)_____ ☐ Whole Foods Massage Therapist_____

☐ Website ☐ Internet ☐ Other: _____

Please be advised, we do not bill health insurance for massage or naturopathy services outside of car accident and workman's compensation claims. If you have any questions please ask the front desk staff.

Health Insurance for Acupuncture, Auto Accident or Workman's Compensation Patients Only:

Ins. Co: _____ Subscriber Name: _____

Subscriber ID#: _____ Group#: _____ Subscriber DOB: _____

Subscriber SSN:_____ Patient SSN: _____

DISCLAIMER

The services available at Whole Health Center are complementary to and not a substitution for treatment by a licensed medical doctor. By signing below you indicate that you understand this disclaimer.

Signature: _____ Date: _____