BostonWellnessMassage & Skin Care

Intake: Contact Information

Name: _____ Circle one: Male / Female

Address: _____ City: _____ State: _____ Zip:_____

Phone: (h) _____ (w) _____ E-mail :_____ D.O.B.: _____

In Case of Emergency: _____ Phone: _____ Relationship _____

Occupation: _____ Referred by: _____

Primary Complaint: _____

Please read carefully and check the appropriate boxes:

o I understand the cancellation policy, as follows:

The clinic reservse the right to charge the full fee for a missed appointment with less than twenty-four (24) hours notice. We will use our discretion when charging "No Show" fees. Also, the right is reserved by the clinic to charge the full scheduled fee for tardiness to appointments.

o My credit card is on-file (if not, please enter card info below)

DISCOVER/VISA/MC # Exp. /

o I understand that my credit card WILL NOT be charged until after the time of my massage. I will have the option whether or not to bill my credit card on the date that I have scheduled the appointment.

Recommendation may be given by the Therapist with reference to future treatments, activities, occupational and sleep mechanics. The Therapist neither diagnoses illnesses, disease or any other physical or mental disorder, nor performs any spinal manipulations. *At times, one may feel some post-therapy tenderness due to the release of toxins and/or the lengthening of connective tissue.*

o I understand that the massage services provided by this licensed Massage Therapist are provided pursuant to and in accordance to the laws of the City of Boston governing massage therapy and that a full and complete medical disclosure is essential in providing such therapy. I agree to hold harmless, release and indemnify this massage establishment against any and all liability arising from the application of massage therapy. By signing this release form, I hereby declare that I have provided the Massage Therapist with all relevant information necessary for the proper application of massage therapy and I expressly give my permission for this Massage Therapist to provide such therapy.

Signature:_____ Date:_____

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Existing Medical Conditions:

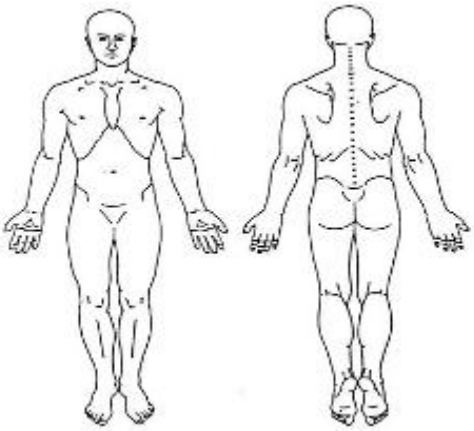
Are you currently under the care of a Physician? If yes, name the Physician and reason:

_____

Are you currently taking any medications? If yes, name and dosage:

_____

Please take a minute to highlight areas of chronic tension, discomfort, or pain; on the diagram below:



5. Are there any activities that make the condition better or worse?

6. Are there any limitations caused by the injury/condition? Y_____ N_____ (if yes, please describe)

_____

7. Do you have any previous injuries that should be known; and do they relate to what you are being treated for today?

_____

8. Are you under any medical/therapeutic treatment? (Y/N)

i.e.: Physical Therapy _____ Chiropractor _____ Acupuncture _____

9. Have any diagnostic tests/exams been completed for this condition?

X-ray____ MRI_____ CT Scan _____ EMG (nerve test)_____

10. Are there any areas, in particular, that you would like your therapist to focus on or stay away from?

Signature:_____ Date:_____