

Away Therapeutic Body Care

Confidential Client Information

Name _____ Home Phone _____
 Mailing Address _____ Work Phone _____
 City, Zip _____ Cell Phone _____
 Email _____ Date of Birth _____
 Emergency Contact _____ Phone _____
 Relationship _____ Alternate Phone _____
 Physician Name _____ Physician Phone _____
 Chiropractor/Other Health Practitioner _____ Practitioner Phone _____

Do I have permission to contact your Physician, Chiropractor/Other? No Yes: Please initial if "yes" _____

Medical Information & Health History • AGE: _____ Male Female

If you have a specific medical condition or specific symptoms massage therapy/body treatments may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Please be sure to include all current conditions you are experiencing or have been diagnosed with, as well as any *previous conditions (please include dates). Mark all that apply and explain as clearly as possible.

WOMEN ONLY

- Premenstrual Syndrome
- Pregnancy: #of weeks: _____
- Nursing Other: _____

VASCULAR/CIRCULATORY

- Varicose Veins
- Atherosclerosis
- Blood Clotting
- Phlebitis/Thrombophlebitis
- High or Low blood pressure
- *Stroke *Heart Attack
- Hypertension
- Cardiovascular Disease:
- Edema
- Other: _____

MUSCULOSKELETAL/

NEUROMUSCULAR:

- Tendonitis:
- Bursitis:
- Plantar Fasciitis
- Arthritis:
- *Sprains/Strains:
- Jaw Pain (TMJ)
- Chronic pain:
- Severe pain:
- *Bone fractures:
- Osteoporosis
- Loss of sensation/tingling:
- Spinal Problems:
- Sciatica
- Recent surgery or Severe Injury
- Other: _____

DO YOU WEAR

- Contact Lenses Dentures

RESPIRATORY:

- Asthma
 - Sinus Problems
 - Allergies
 - Other: _____
- #### IMMUNE SYSTEM
- *HIV/AIDS
 - *Hepatitis
 - *Herpes
 - Fever Cold or Flu
 - Lymphnode removal
 - Lymphangitis Swollen glands
 - Malignant melanoma
 - Other: _____

OTHER:

- Nicotine/Alcohol/Drug Addiction
- Digestive problems:
- Hernia
- *Cancer:
- Fatigue:
- Fibromyalgia
- Stress:
- Peritonitis
- Ulcers
- Diabetes:
- Frequent headaches
- Migraines
- Depression
- Insomnia/Restlessness
- Other: _____

SKIN:

- Severe Acne or skin infections
- Skin allergy or rash
- Skin lesions, open wounds, boils
- Herpes simplex Impetigo
- Fungal infection, warts, ringworm
- Severe bruising bruise easily
- Healing cuts/scrapes/burns/bruises
- Inflammation
- Loss of sensation or tingling:
- Sensitivity to pressure/touch:
- Other: _____

COMMENTS: _____

SURGERIES IN THE LAST 5 YRS:

CURRENT PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS & SUPPLEMENTS:

...USED FOR

Assessment Information

Occupation: _____

Hour of work per week: _____

Have you ever experienced professional massage therapy? No Yes: How recently? _____

How often do you receive massage? _____

Which type/pressure do you prefer? (mark all that apply):

MANUAL Lymphatic Drainage gentle/intuitive light
 medium firm deep Myofascial/Deep Tissue

Have you ever experienced a therapeutic body treatment or Steam Therapy before? Yes No

If yes, what kind of treatment? _____

Do you exercise at least twice a week? Yes No

If yes, what kind? _____

How do you typically relieve daily stress? _____

Rate your current level of stress: 1 2 3 4 5

(1 = not stressed at all, 5 = extremely stressed)

Sugar Intake: Frequent Moderate Rare Never

Caffeine Intake: Frequent Moderate Rare Never

Reason for appointment, expectations & session goals: _____

Please circle any areas of your body where you **DO NOT** want to receive massage: *Scalp* *Face*
Neck *Shoulders* *Arms* *Hands* *Chest* *Abdomen* *Hips/Buttocks* *Thighs* *Legs* *Feet*

COMMENTS: _____

INDICATE & DESCRIBE SPECIFIC AREAS OF CONCERN

TENSION, SORENESS, INJURY, LIMITED RANGE OF MOTION, ETC.:

DESCRIBE YOUR EXPERIENCE WITH YOUR SPECIFIC AREA (S) OF PAIN OR TENSION:

Duration:

- Hours
- Days
- Weeks
- Months

Type:

- Sharp
- Dull
- Achy
- Tingly

Severity:

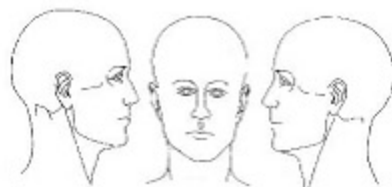
- Mild
- Moderate
- severe

Frequency:

- Seldom
- Intermittent
- Frequent
- Constant

Onset:

- Sudden
- Gradual



How would you rate your body's level of flexibility?

1 2 3 4 5

(1 = not flexible at all, 5 = extremely flexible)

Rank your top three (1-3) health goals in order of their priority to you (1 = highest priority):

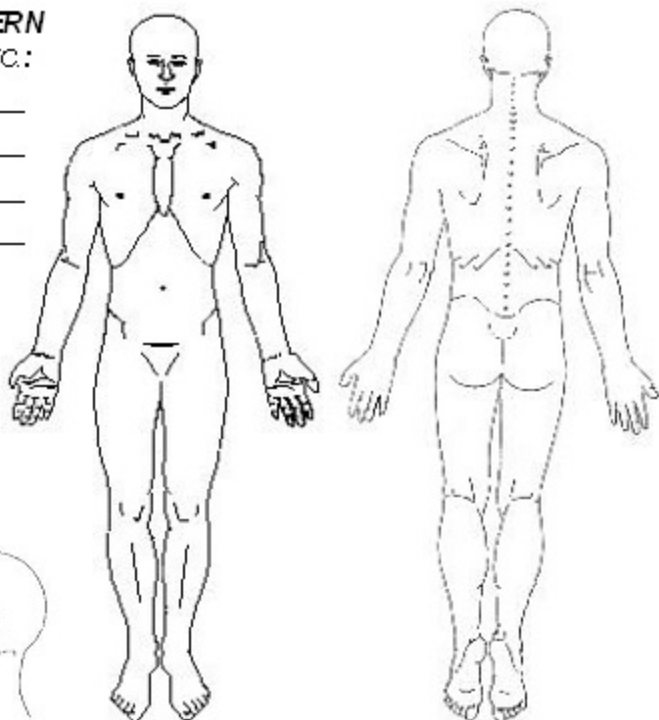
- _____ Enhancing Athletic Performance
- _____ Improving Cardiovascular Circulation
- _____ Increasing flexibility
- _____ Injury Care
- _____ Pain Relief
- _____ Strengthening
- _____ Stress Management
- _____ Other: _____
- _____ Other: _____

How many ounces of water do you drink daily?

- none 8-16 24-32 40-48
- 56-64 72-80 more

Alcohol Intake: Frequent Moderate Rare Never

Nicotine Intake: 2+packs 1+packs 0-1 pack Never



APPOINTMENTS: For the most expedient service, please call to schedule your appointment 1 to 2 weeks in advance. Scheduling for your next session at the time of your appointment is also highly recommended. Time slots are limited & tend to fill up quickly. Occasionally, I can accept same-day appointments, but I typically require a minimum of 3 to 5 days advance notice. Appointments are confirmed by phone call the morning of, or the day before, your session.

ARRIVAL: Please arrive 5 to 10 minutes prior to your scheduled appointment time to assure the full allotted time to complete your service. Allow time for disrobing & dressing, as well as communicating with me before & after your session. If you are late, I will do my best to have you receive your scheduled time on the table. However your session may be shortened or adjusted to allow me to stay on schedule for any following appointments. Fee for service (s) scheduled will apply.

CANCELLATIONS & RESCHEDULING: Please notify me as soon as possible of conflicts so other clients may utilize your appointment time. If possible, kindly give 24 hours notice to cancel or reschedule. Please give 48 hours cancellation notice for appointments 2 hours or more in length. If I need to alter appointment times, I will make every effort to inform clients in a timely manner, and will provide a 50% discount for less than 4 hours notice, on client's next appointment.

MISSED APPOINTMENTS: Missed Appointments may be subject to a fee of 50% of the service (s) scheduled. I reserve time especially for you. Late Cancellations & No-Shows affect me significantly. Therefore, I require a minimum of 4 hours notice for all cancellations in order to avoid this fee. Emergency cases will be determined at practitioner's discretion. Payment for the missed appointment must be made before rescheduling for the next appointment. Thank you for your cooperation & understanding.

GIFT CERTIFICATES & COUPONS: Good for dollar amount only; Cannot be redeemed for cash; Single services *may not* be divided into multiple sessions; Are transferable from one person to another. You must have your certificate/coupon at the time of your appointment or a full charge will apply. Prices & services are subject to change without notice. Gift certificates are honored for two years. After that date, if the gift certificate is unused, I will value 100% of the dollar amount paid for the gift certificate towards that day's current prices. Only one non-cancelable appointment can be made for an

expired gift certificate. No-shows on gift certificates will render certificate null and void, late cancellations will deduct 50% of certificate value.

MODESTY: Individual privacy is highly respected. Clients are properly draped throughout all services. No exceptions.

SCOPE OF PRACTICE: I perform services only for which I am able (physically & emotionally), and qualified to do. I refer to appropriate specialists when work is out of my scope of practice and/or not in the client's best interest.

ALL SERVICES PROVIDED ARE NON-SEXUAL

RIGHT OF REFUSAL: I reserve the right to refuse service to any one. This includes but is not limited to: 1. Any individual who requests or suggests sexual or illicit services. I reserve the right to terminate a session for sexual requests, suggestions, or advances. I reserve the right to charge for the session time whether or not scheduled services were rendered. A payment IN FULL will be due, and the local law authorities may be notified; 2. Any individual who arrives for therapy under the influence of alcohol or recreational drugs. I reserve the right to charge for the session time whether or not scheduled services were rendered. A payment in full will be due; 3. Any individual currently taking prescribed medications, or who possess a health condition, which is contraindicated for a massage.

NO-DISCRIMINATION: All clients are treated with respect and dignity. I do not discriminate against client's race, religion, sexual orientation, political views, or gender.

TEENS & CHILDREN: AGES 17 AND YOUNGER: Are required to have a parent or legal guardian sign their Client Information forms. Teens & children ages 15 & under are required to have a parent, or responsible adult, accompany them to their appointment. *Having a parent, or responsible adult, present in the treatment room during a session is left to the parent's discretion/ client's preference. Whatever is comfortable and acceptable for everyone is best.

LOCKED DOOR & TELEPHONE POLICY: Because I do not have a receptionist, my policy is to lock the door and to not answer my phone while we are in session. I request that you please turn off your cell phone, or pager, as well (unless there are special circumstances in which you must be contacted during this time). This allows for a peaceful session without interruption.

PAYMENT: Payment for service(s) is due at the time of appointment, (unless prepaid). **Cash, Checks, Debit Card, Visa, MasterCard.**

CLIENT AGREEMENT

It is my choice to receive massage therapy (or body treatments). I understand that the services provided are for the well being of my body and mind, and to enhance my body's natural healing processes. This includes stress reduction & relaxation, relief from muscular tension, spasm, or pain, and increased circulation. If I experience any pain or discomfort during a session, I will immediately inform the practitioner so that the pressure and/or techniques may be adjusted to my level of comfort. I agree to communicate with my practitioner any time I feel my well-being is being compromised.

I understand that any information provided by the massage practitioner is for educational purposes only. I understand that massage practitioners are not qualified to diagnose, prescribe, or treat any physical or mental illness; nor do they prescribe pharmaceuticals or perform spinal or skeletal adjustments, and that nothing said in the course of the session should be construed as such. I realize that there is no stated or implied guarantee of effectiveness for massage and body treatments.

I understand that massage or body treatments should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, or other qualified medical specialist for any mental or physical ailment of which I am aware. Because massage and body treatments 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 in my health status, and understand there shall be no liability on the practitioner's part should I fail to do so.

I understand that the client/practitioner relationship will be held in strict confidence. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, or refusal of service by the practitioner, and I will be liable for full payment of the scheduled appointment. I have read and understand that I will be responsible for a payment of 50% of the service (s) scheduled without at least 4 hours notice of cancellation. I understand and agree to comply with all of the above policies.

I HAVE OBTAINED A COPY OF THE ABOVE POLICIES AND CLIENT AGREEMENT.

Client Signature: _____ Date: _____

Consent to treatment of minor: By my signature below, I hereby authorize Wendi R. Wells, Massage Practitioner, to administer massage therapy or body treatments to my child/dependant as deemed necessary.

Parent/Guardian Signature (if Client is a minor): _____ Date: _____

I was referred by: _____