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A Center for Massage

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1845 Sunset Point Rd. • Clearwater, FL 33765 • 727.796.8653 • Fax: 727.468.9431
www.center4massage.com • Founded in 1992 • Est. Lic #0003702

CONFIDENTIAL NEW PATIENT INFORMATION

We guarantee that your information will never be provided to any outside source unless preauthorized.

Date: _____

Name: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Home Phone #: (___)_____ Email: _____

Do you wish to be included on our occasional mailings and email notifications regarding specials, new services and other massage related information about A Center For Massage? _____ Yes _____ No

Date of Birth: _____ Business Phone #: _____

Employer: _____ Job Description: _____

You found us by way of: website____ yellow pages____ sign location____ advertisement ____ other ____

Friend: _____ By Whom: _____

In Case of Emergency: _____ Phone #: _____

Are you under the care of a physician now?_____ If so, Physician's Name: _____

Agreement of Terms

I understand it is important to arrive on time to receive full benefit of my massage time and I understand that 18 hrs. notice is required for cancellation of appointments and I will be charged for missed appointments without proper notice at 50% the normal rate. I understand it is my responsiblity to provide pertinent health information and to inform the therapist of any changes.

I understand and agree that massage services provided by our licensed Massage Therapists are intended for the relief of muscle tension or spasm, reduction of stress and to assist venous and lymphatic circulation. Massage Therapists do not diagnose disease, prescribe medications or manipulate the spine.

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

I understand and agree that payment for services rendered are my responsiblity and are to be paid at the time services are provided.

Signature: _____ Date: _____

(Please turn over and continue to fill out form)

CONFIDENTIAL CASE HISTORY Name: (Please Print)_____

Check the reason(s) for the appointment: ____ stress relief ____ relaxation ____ pain relief ____ injury

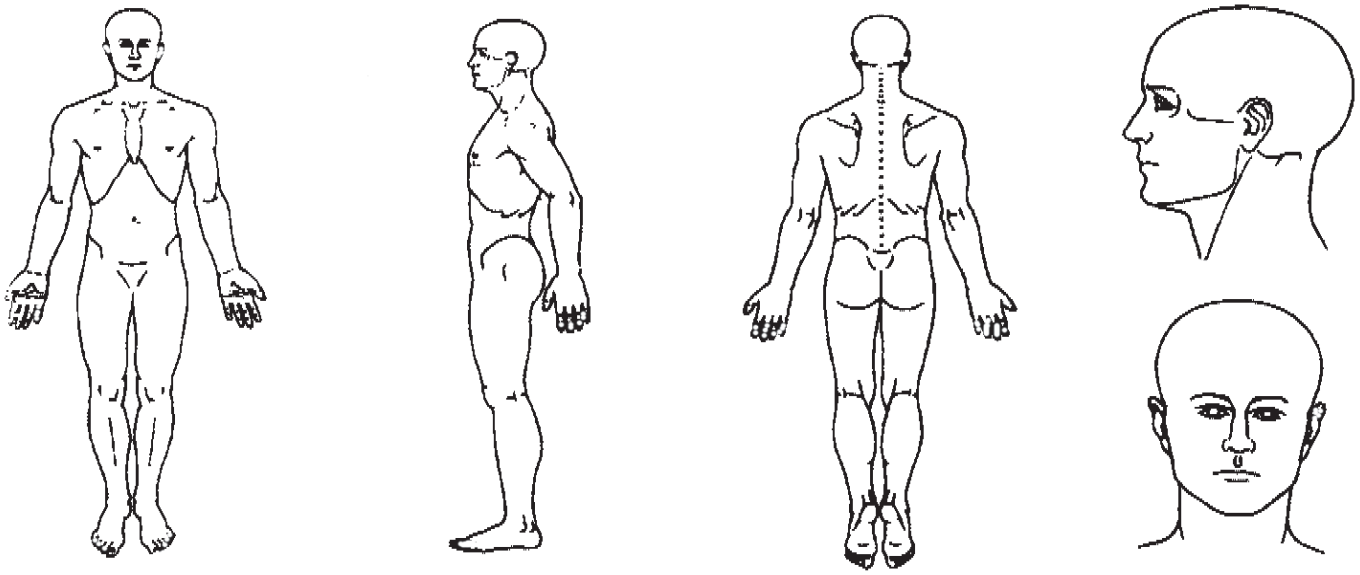
Please describe your symptoms:_____

_____

When did you first notice complaint?_____

Cause: _____

PLEASE CIRCLE OR MARK ANY AREA OF PAIN OR CONCERN.



Have you recently been exposed to a contagious disease?_____ If so, what?_____

Are you experiencing flu or cold-like symptoms:_____

Do you exercise?_____ Please describe your routine:_____

Do you have any other medical conditions I should be aware of?_____

_____ Are you pregnant? _____

Current medications?_____

Please circle what your diet includes: Meat Dairy Vegetables Fruit Alcohol Caffeine Smoking

Please indicate each of the following that you have or have had in the past:

__ ALLERGIES:
Lotions ____
Other_____
__ ARTHRITIS
__ BLOOD CLOTS
__ BLOOD PRESSURE HIGH/LOW
__ BURSITIS
__ CANCER_____
_____

__ CIRCULATORY DISORDERS
__ DEPRESSION
__ DIABETES
__ DISC PROBLEMS
__ DIZZINESS/FAINTING
__ FIBROMYALGIA
__ HEADACHES
__ HEART CONDITIONS
__ HEPATITIS

__ INJURIES
__ MIGRAINE HEADACHES
__ MULTIPLE SCLEROSIS
__ MUSCLE SPASMS
__ NERVOUSNESS
__ NUMBNESS IN HANDS/FEET
__ OSTEOARTHRITIS
__ OSTEOPOROSIS
__ PAINFUL JOINTS

__ RHEUMATOID ARTHRITIS
__ SCIATICA
__ SCOLIOSIS
__ SKIN PROBLEMS
__ SPINAL PROBLEMS
__ SURGERIES/OPERATIONS
__ TINGLING IN ARMS/LEGS
__ VARICOSE VEINS
__ OTHER

THIS SECTION FOR OFFICE STAFF ONLY

Therapist's Notes:

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