Massage New Patient Form

Name _____

Address _____

City, State, Zip _____

Date of Birth_____

Home Phone # ( ) _____ Cell/Work Phone # ( ) _____

SSN# _____ Email Address _____

Gender M / F Occupation _____

Emergency

Contact _____ ( ) _____

1. List stress reduction and/or exercise activities, including frequency:

_____

_____

2. List current medications, including ibuprofen, herbal remedies, etc:

_____

_____

3. If you are currently under the care of a health care practitioner for any condition/injury, please provide:

Practitioner Name _____

Phone ( ) _____

4. List any surgeries, injuries/accidents, major illnesses or other hospitalizations within the last 5 years or for conditions still affecting you:_____

_____

_____

5. If this visit is related to an accident or injury, please provide date of accident/injury: _____

6. Do you have any allergies to oils, lotions, or ointments? _____ If yes, Please explain. _____

_____

Please indicate if you now, or have in the past, had any of these conditions:

Now	Past		Now	Past		Now	Past	
☐	☐	Bone or Joint Disease	☐	☐	Heart Condition	☐	☐	Breathing Difficulty
☐	☐	Tendonitis/Bursitis	☐	☐	Varicose Veins	☐	☐	Emphysema
☐	☐	Sprains/Strains	☐	☐	Blood Clots	☐	☐	Asthma
☐	☐	Low Back/Hip/Leg Pain	☐	☐	High Blood Pressure	☐	☐	Sinus Problems
☐	☐	Neck/Arm/Shoulder Pain	☐	☐	Low Blood Pressure	☐	☐	Allergies
☐	☐	Spasms/Cramps	☐	☐	Lymph edema	☐	☐	Chronic Fatigue
☐	☐	Jaw Pain/TMJ	☐	☐	Thrombosis/Embolism	☐	☐	Sleep Disorders
☐	☐	Osteoporosis	☐	☐	Gas/Bloating	☐	☐	Constipation/Diarrhea
☐	☐	Rashes	☐	☐	Diverticulitis	☐	☐	Numbness/Tingling
☐	☐	Athletes Foot	☐	☐	Ulcers	☐	☐	Trigeminal Neuralgia
☐	☐	Herpes/Cold Sores	☐	☐	Irritable Bowel Syndrome	☐	☐	Bell's Palsy
☐	☐	Ulcers	☐	☐	Pinched Nerve	☐	☐	Migraines/Headaches
☐		Pregnancy;___mths	☐	☐	Cancer/Tumors	☐	☐	Anxiety/Stress
☐	☐	PMS	☐	☐	Kidney/Bladder	☐	☐	Depression
☐	☐	Prostrate	☐		Diabetes			
☐	☐	Other_____						

What areas would you like to concentrate on during your massage?

Symptom/Area(s) _____

Pain Level (0 to 10) _____ Duration/How long has this bothered you? _____

Additional remarks or coments:_____

Signature _____ Date_____

JOHNS CREEK WELLNESS CENTER MASSAGE PATIENT POLICIES

Massage Appointment Policy

Massage Therapy is offered by appointment only. There is a $50 deposit required at the time of scheduling to reserve your appointment. The deposit will be forfeited without a 24 hour notice of cancellation. Full payment is due at the time of service. Your deposit will be applied towards the balance owed for services.

Your appointment time has been set aside especially for you. If you are late, your massage will still end at the scheduled time.

I agree to give 24 hours notice if I must cancel my appointment. I agree to pay full service fee as the cancellation fee to the massage therapist for missed appointments not cancelled within 24 hours.

Initials: _____

Financial Policy

1. It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately the patient is responsible for all services, including those not reimbursed by third party payers.
2. All payments are expected at the time of service.
3. All insurance assignment patients must pay their deductibles in full and the co-payment at the time of service.
4. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1.5% per month. A full service fee will also be due for missed appointments and those cancelled without 24 hours notice. All accounts that require being sent to a collection agency or attorney will be assessed a one hundred dollar administrative fee.
5. All accounts not paid within 30 days, and after attempted contact will be submitted to collections.

Initials: _____

Release

1. Because a massage therapist must be aware of any existing physical conditions, I have listed all my known medical conditions and physical limitations. I will inform Johns Creek Wellness Center in writing of any changes in my medical profile and understand that there shall be no liability on Johns Creek Wellness Center or the therapist's part should I fail to do so.
2. I understand massage therapist are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. I am responsible for consulting a qualified physician for any physical aliment that I have.
3. I understand that I must inform the massage therapist if I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

Signature _____

Date _____