

**Office Policies  
Naturally Connected**

**Therapeutic Massage**

Swedish massage, trigger point therapy, deep tissue structure work, hydrotherapy, hot rocks, use of essential oils and various other modalities to customize your treatment.

**Cancellations / Late arrivals / No shows**

If a client fails to show up without notice, they will be charged for the full amount of what the client made the appointment for.

Please arrive on time because you will only receive the remaining time left and be charged for the full time set aside for you.

If it is necessary to cancel or reschedule an appointment, I ask that you please think of others that may want your spot and give a 24 hour notice.

**Payment Options**

Cash ,Check, Visa, Debit, Master Card.

**Insufficient Fund Checks**

If a client pays with a check that does not clear with the bank, there will be a \$30.00 processing fee plus the amount of the check. The client who writes one check that does not clear will be required to pay in cash for any further sessions.

**Confidentiality Waiver**

All information is kept confidential, except upon the written request from the client.

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Client Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Married: Yes No  
 Date of birth \_\_\_\_\_ Employer: \_\_\_\_\_  
 Hobbies: \_\_\_\_\_  
 Referred by: \_\_\_\_\_  
 In case of emergency: \_\_\_\_\_  
 Email Address \_\_\_\_\_  
 Phone numbers Cell \_\_\_\_\_ Home: \_\_\_\_\_ other: \_\_\_\_\_

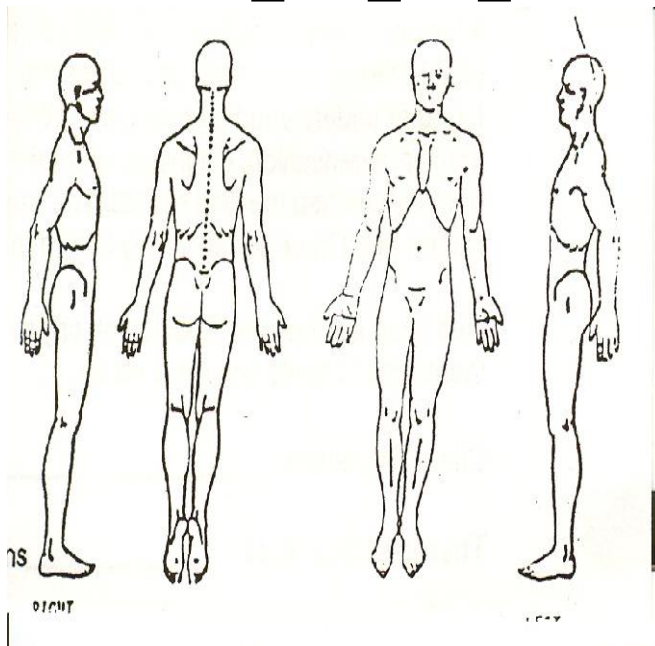
General and Medical information: Please check any of the following that apply to you.

- Allergies/oils, creams, smells
- Asthma
- Athletes foot
- Back pain
- Bruise easily
- Cancer / Type \_\_\_\_\_
- Constipation / Colostomy
- Contacts
- Diabetes
- Dizziness / vertigo
- Eczema
- Epilepsy
- Face or Head injuries
- High or Low Blood Pressure
- Heart Disease
- High Cholesterol
- HIV Positive
- Hypersensitive Skin
- Joint Pain
- Joint replacement Type: \_\_\_\_\_
- Lung condition
- Sleep difficulties
- Migraine
- Headaches
- Osteoporosis
- Pregnancy #of wks \_\_\_\_\_
- Prosthesis \_\_\_\_\_
- Scaly
- Moles

list surgeries  
 w/dates: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Primary reason for today's  
 appointment: \_\_\_\_\_  
 \_\_\_\_\_

Check area you **do not** want massaged

- Face  Neck  Abdomen
- Shoulders  Arms  Legs
- Head  Back  Feet



- Warts
- Impetigo
- Sores that will not heal
- Tension
- TMJ
- Varicose Veins
- Blood Clots
- Any other ailment that you feel the therapist should know about.

Are you under the care of medical doctor, Chiropractor or other health care professional?  If yes, Please explain.

---



---

Prescribed Medications, Herbs, Vitamins, Insulin, muscle relaxant, blood thinner, estrogen, anti-coagulant, anti-depressant, beta blocker, bronchial dilator, and over the counter medications you are currently taking: Please describe the reason for the prescribed medications. \_\_\_\_\_

---

Is there any essential oils that you are sensitive to? \_\_\_\_\_

---

Is there any part of your body that is touch sensitive? \_\_\_\_\_

---

Have you ever had massage therapy prior to this visit? \_\_\_\_\_

If you have had a massage prior, how was your experience?

---

What would you like to see accomplished at this therapy session? \_\_\_\_\_

---

Please take a moment to read:

If you have a specific medical condition or specific symptoms, massage / bodywork may not be appropriate. A referral from your primary care provider may be required prior to service being provided. I understand that massage / bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension.

If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and / or technique may be adjusted to my level of comfort.

I further understand that massage / bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of.

I affirm that I have stated all my known medical conditions and answered all the questions honestly.

I will keep my therapist updated on any medical changes and there will be no liability on the therapist if I should neglect to do so.

Client

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

-