Confidential Health Information

Name: _____ DOB: _____ Age:_____

Address: _____ Phone: _____

_____ Email: _____

Doctor& Phone #: _____ Occupation: _____

Personal Trainer (if applicable) _____

For increased effectiveness, are you agreeable for clinical information to be shared with your trainer/ doctor?
YES NO

Purpose of Visit

___ Increase joint flexibility and range of motion
___ Enhance athletic performance
___ Rehabilitate from injury or surgery
___ Eliminate pain
___ Decrease mental stress
___ Preventative health care/ maintenance
___ Increase well-being
___ Other _____

General Medical Information

Please check any of the following conditions that apply to you:

___allergies
___arthritis
___asthma
___cancer
___corrective lenses (eyes)
___depression
___diabetes
___epilepsy
___fractures (bone)
___headaches
___heart disease
___high blood pressure
___HIV/ AIDS
___pregnancy
___recent surgery
___spinal issues (i.e. disc protrusion, scoliosis)
___stroke/ arteriosclerosis
___stress
___trauma
___varicose veins/ blood clots

Do you have any other medical conditions we should be aware of? _____
Please list any medications, frequency of intake, and reasons for taking them:

_____

_____

Are you sensitive to touch/ pressure in any area? _____

Requests/ Comments:

_____

_____

_____

KETCHUM BODYWORKS
SPORTS MASSAGE

OFFICE POLICY AND AGREEMENT

Payment is due at the time of your appointment.
Cancellation within 24 hours prior to a scheduled appointment will incur the full charge.

WAIVER

If you have a specific medical condition or specific symptoms, massage and manual therapy work may be contraindicated. A referral from your primary care provider may be required prior to services being provided.

I understand that if I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/ or strokes may be adjusted to my level of comfort. I further understand that massage and manual therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that the attending massage/ manual therapist is not qualified to perform high velocity spinal or skeletal adjustments, diagnose, or prescribe medication for any physical or mental illness, and that nothing said in the course of the session(s) given should be construed as such. Because massage and manual therapy is contraindicated 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 medical profile, and understand that there shall be no liability on the practitioner's part should I forget to do so. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I understand and agree to all of the above and consent to treatment.

Signed: _____ Date:_____