CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

Personal Information **Todays date:_____/_____/_____**

First Name: _____M.I. _____Last Name: _____

Address_____City:_____State: _____Zip:_____

Phone(h): _____ Work(w): _____ Cel:_____

Date of Birth: _____/_____/_____ SS#:_____/_____/_____ Marital Status: _____

Employer: _____Occupation: _____

Emergency contact name : _____ Phone:_____ Relationship: _____

Referred by:_____Your e-mail: _____

Current Physician's name:_____ Physician's phone # _____

Massage Experience:

Is this your first professional massage? Yes No. If no, how frequently do you get a massage? _____X a month , Week etc

If yes, what types of massage have you had (Swedish, shiatsu, deep tissue, etc.)? _____

How long have you been receiving massage therapy? _____ Frequency of massages ? _____

What do you hope to accomplish from today's massage? _____

Current Health

Do you exercise regularly or participate in any sports? Y N If yes, what kind of exercise/sports?_____

Do you perform any repetitive movement in your work, sports or hobby? Y N If yes, describe_____

Do you sit for long hours at a workstation, computer or driving? Y N If yes, describe _____

Do you experience stress in your work, family, or other aspect of your life? Y N If yes, describe _____

Are you experiencing tension, stiffness, discomfort or pain? Y N If yes, describe _____

Have you recently had an injury, surgery, or areas of inflammation? Y N If yes, describe _____

Do you have sensitive skin? Y N Do you have any allergies to oils, lotions or ointments? Y N If yes, please explain _____

List any medications you are currently taking_____

List any known allergies _____

Are you aware of any tension holding spots in your body? _____If yes, location(s)_____

Describe any surgeries, hospitalizations, accidents or injuries that you have had: _____

Less than 5 years ago: _____ More than 5 years ago: _____

What kind of care did you receive for your accidents or injuries? _____

Do you feel that you have recovered from these events? _____Please explain: _____

Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals (include explanation of what medication is used to treat): _____

Are you currently under the care of your current or other physician? _____IF yes Whom? _____

Please list reason(s):_____

Do you have any chronic, ongoing pain that you deal with on a regular basis? If Yes Please explain: _____

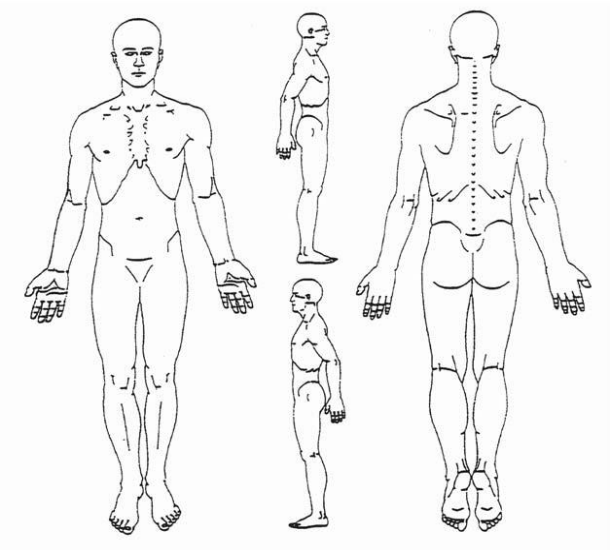
Describe what activities cause this pain and/or make it worse: _____

Are you receiving any other type of medical treatment? If Yes please explain: _____

Are there any other health concerns you wish to discuss today? If yes, please describe: _____

Are you currently experiencing any of the following conditions?
__Flu or Cold __ Inflammation __ Fever __ Infection __Contagious Disease

Pease indicate where you experience pain on the drawing below



Health history (Please check any of the following conditions below that currently affect. you or that you have experienced in the last 5 years)

Musculoskeletal

___Bone or joint disease
___Tendonitis
___ Bursitis
___Cysts
___Carpal Tunnel Syndrome
___Jaw Pain (TMJ)
___Migraines
___Headaches
___Fibromyalgia
___Gout
___Plantar Fascitis
___Tendonitis
___Torticollis
___Sprains/Strains
___Spasms/Cramps
___Sciatica
___Low Back Pain
___Hip Pain
___Leg Pain
___Mid Back Pain
___Neck Pain
___Arm Pain
___Shoulder Pain
___Spine Injury
___Sport Injury
___Whiplash Syndrome
___Thoracic Outlet Syndrome
___Postural Deviations
___Osteoarthritis
___Rheumatoid Arthritis
___ Other ____

Respiratory

___ Emphysema ___Sinusitis
___Sinus Problems ___ Dizziness
___Allergies, specify:
___Asthma ___ Pneumonia
___ Trouble Breathing
___Other_____

Reproductive

___Pregnancy
(Pregnant____stage
Ovarian/Menstrual Problems
Prostate ___ PMS

Nervous System

___Shingles
___Numbness
___Tingling
___ Twitching
___Pinched Nerve
___Chronic Pain
___Paralysis
___Multiple Sclerosis
___Parkinson's Disease
___ Stroke
___ ALS
___ Bell's Palsy
___ Neuritis
___ Spinal Cord Injury
___ Seizure
___ Trigeminal Neuralgia Disorders
___ Other _____

Circulatory

____Heart Condition
___ Anemia
___Phlebitis
___Varicose Veins
___Blood Clots/Phlebitis
___Thrombosis/Embolism
___High Blood Pressure
___ Low Blood Pressure
___ Lymphedema
____ Edema
___Diabetes
___Hemophilia
___ Raynaud's Disease
___Other
_____

Digestive

___Ulcers
___Bladder Infection
___Kidney Disease
Ailment Colitis
___Crohn's Disease
____ Gallstones
____ Hepatitis
____ Diarrhea
____ Gas/Bloating
___ Indigestion
_ _Irritable Bowel Syndrome
____ Colitis
Other _____

OTHER

____ Insomnia
____ Anxiety/Panic Attacks
____ Grief Process
____ Cancer
____ Substance Abuse
____ Chronic Fatigue
____ HIV/AIDS
____ Lupus
____ Postoperative Situation
____Other

Skin

Allergies, specify:
___Rashes
___ Acne
___Herpes
___ Psoriasis
___ Warts
___Moles
___Cold Sores
___Open Wound
___Open Sore
___ Fungal Infections
___ Impetigo
___ Dermatitis/Eczema
___ Athletes Foot
___Cosmetic Surgery
___Other

Psychological

Anxiety/Stress Syndrome
Depression

COURTESY AGREEMENT

Dear patient:

Your time is valuable to me. Every effort is made to keep my schedule running on time. I maintain extended office hours, and avoid overbooked appointments. A scheduled appointment is a commitment you and I share.

Patients that do not show up for an appointment, late, cancel or reschedule without 24 hours notice via email NO TEX undermine the efficiency of the office and negatively impacts on other patient's schedules.

Please be courteous and extend the same level of consideration to my schedule and to other patient's schedules.

EFFECTIVE IMMEDIATELY AT THE TIME OF SIGNING

Patient will be charged the full cost of their appointments who:

- Do not show for an appointment
- Are at least 20 minutes late for their appointment and are unable to be seen.
- Fail to provide 24 hours notice via email NO TEX PLEASE prior to cancelling or rescheduling an appointment.

Payment is due at the time of the appointment. This charge is your personal responsibility and not covered by insurance.

I, _____ understand and agree to the terms of the Courtesy Agreement.

_____

Patient Name (Print)

_____ _____

Patient Name (Signature) Date

client agreement

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy
is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that the Massage by Netranie, LLC has provided this form as a reference and is not held liable for any services provided.

_____ _____

Signature date

All information I provided on this form is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take full responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

_____ _____

Signature: date

CANCELLED AND MISSED MASSAGE APPOINTMENTS

Please understand that your time commitment begins at the moment you reserve a massage appointment. In order to make it fair for everyone, please consider your schedule carefully and don't commit to a time that you feel may be questionable. There are times when a cancellation is, of course, necessary; but please give advanced notice whenever possible. Missed or cancelled appointments (medical emergencies excluded) without twenty-four (24) hour notice via email (NO TEX) will be charged in full for the missed session. I have read and understand the above policy

_____ _____

Signature date:

assignment of benefits

I am responsible for all charges for all service provided. In the unfortunate event that my insurance company denies payment, or makes a partial payment, I am responsible for any balance due. If you, my massage therapist, have contracted with my insurance company at a discount rate for services, the
amount remaining will be waived and I will not be asked to pay the balance. I authorize and direct payment of medical benefits to my massage therapist, for services billed.

_____ _____

signature date

_____ _____

signature of parent or legal guardian (if client if a minor) date

release of medical records

I authorize the release of medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys, healthcare providers, and insurance case managers, for the purposes of processing my claims.

_____ _____

signature date

_____ _____

signature of parent or legal guardian (if client if a minor) date

(Please inform your practitioner immediately upon signing any exclusive Release of Medical Records with your attorney that may impact the above release statement.)

contract for care

I will participate fully as a member of my healthcare team. I will make sound choices regarding my sessions' plan based upon the information provided by my massage therapist. I agree to participate in my own self-care programs and adhere to the plan we select. I agree to communicate with my practitioner any time I feel my well-being is being compromised. I expect my practitioner to provide safe and effective treatment to the best of his or her skills and knowledge.

_____ _____

signature date

_____ _____

signature of parent or legal guardian (if client if a minor) date

Pregnancy Questionnaire

Patients Name First _____ Last _____

Todays Date _____ Delivery Due Date: _____

Name of Obstetrician _____ Phone _____ Email _____

Name of Midwife _____ Phone _____ Email _____

Please describe how you have felt (physically and emotionally) during this pregnancy: _____
_____

Have you had any complications or abnormalities?_____ If yes, please describe: _____
_____

If yes, do you have the approval of your midwife or physician to receive massage? _____

Do you have any of the following conditions or symptoms? • High Blood Pressure • Fever • Diarrhea • Diabetes
• Abdominal Pain (unusual pain) • Preterm Labor • Varicose Veins • Toxemia/Preeclampsia
• Decreased Fetal Movement in past 24 hours • Excessive Swelling of Hands, Legs and/or Face
• Vaginal Bleeding &/or Abnormal Discharge

(The above conditions are contraindicated for massage – If you marked any of them your therapist may

need the approval of your physician to continue or may not be able to work on you at this time.)

Have you eaten within the last 3 hours?_____ Are you sensitive to any scents or smells?_____

Are you experiencing any tension or soreness in your muscles at this time?_____If yes, please describe:_____

Is there anything else you would like to discuss about your pregnancy?_____

The above information is accurate and true to the best of my knowledge. I understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for updating my practitioner to any physical, mental or emotional changes that occur with my health during my pregnancy. I agree that I am seeking massage voluntarily for treatment of mild discomfort due to pregnancy and/ or relaxation to me and my baby. Any other reason or intention I have for seeking massage during pregnancy I have discussed with my therapist; and I have disclosed all information that may relate.

Signature:_____Date:_____