Self Balance Massage, LLC ~ *Health Information*

8221 NE Hazel Dell Ave., Suite 103 Vancouver WA 98665 • (360) 977-6090

Name: ____ **Birth Date:** ____/____/____

Address: _______________________ **City:** ____________ **State** ______ **Zip** _________

Phone: ( ) ____________ home / cell **Texting Ok?** yes / no

Occupation: _________________________ **E-mail:** ______________________________

In case of an emergency, please contact: _______________________ **Phone:** ____________

1.Have you ever received a massage or spa treatment before? **yes** **no**

2. Do you have any allergies to essential oils, certain cream/lotion? **yes** **no**

3. Do you have any medical conditions or injuries that we need to know about? **yes** **no**

If yes, please explain. ____

4. Are you currently taking any medications? **yes** **no**

If yes, what? ____

5. Are you pregnant? **yes** **no** *If yes, see the back of this form.*

• **How did you hear about Self Balance Massage?**

gift *website* *sign* *Chuck's* *Yelp* *referral /who* ________________ *other* ______________

• **How often would you like a massage?** *2x month* *monthly* *6x/year* *4x/year* *other* ____________

• **Do you consider massage therapy an important part of your health regimen?** yes no

• **Do you have a health savings account?** yes no

I have provided all my known medical conditions and injuries. I understand that the services offered today are not a substitute for medical care. I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, increased circulation. If I experience pain or discomfort during the session, I will immediately inform my practitioner so that the pressure/strokes can be adjusted to my level of comfort. I will not hold my practitioner responsible for any pain or discomfort I experience during or after the session. I give my consent to receive treatment.

Signature: ____ Date: ____/____/____

Signed Parent/Guardian Permission if participant is under 18 years of age

Signature of parent: ____ Date: ____/____/____

Office Use:

___ *Cx* ___ *MC* ___ *TY* ___ *CHP* ___ *Other Insurance* ______________________________

________ initial

Session Time

Please arrive 5 minutes before your service so you can receive your full amount of hands on time. Your massage will end on time so that the next client is not inconvenienced, and the ***full treatment price will apply.*** In the event that we are running late, you will still receive your full amount of scheduled time.

________ initial

Draping /Coverage

We drape or cover the body using a sheet or towel when doing massage and spa treatments. We do this because it is required by law, and because we feel most comfortable working that way. If you are a client who wishes to receive a massage without being covered, please seek a different massage therapist.

________ initial

Cancellation / No Show

A 24-hour cancellation notice is appreciated. All no call/no shows will be billed 1/2 of the session fee and collected at your next appointment. If you are using a gift certificate, rather than being billed, your massage will be considered as having been used.

________ initial

Delinquent Accounts

We will assess & collect any additional fees related to collection of delinquent accounts.

Pregnancy Massage Therapy Release

*If you have been told that your pregnancy is in a **high risk category**, please discuss massage therapy with your physician or prenatal healthcare provider, and request their written approval.*

I verify that I am experiencing a ***low risk pregnancy***.

I understand that I will be receiving massage therapy as a form of adjunctive health care only and that this therapy is not intended to replace appropriate medical care.

I also agree to hold harmless and defend the practitioner from all actions, claims, legal or administrative action that arises or may arise directly or indirectly out of my and my child's participation in massage therapy.

I give my consent to receive massage therapy treatment.

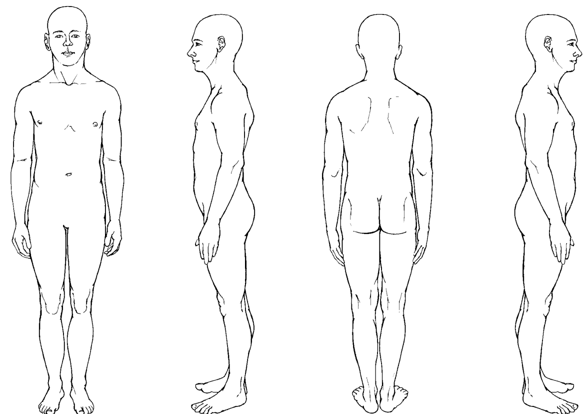
Signature: ______________________________

Date: ____/____/____

Office Use:

Tx: ______________________________

C: ______________________________



date ________________ initials __________