Westside Herbs Acupuncture & Massage

Client # _____

Welcome - Massage

Client Information

First name		Middle		Last Name	
Gender	☐ F ☐ M	Date of birth	_ _ / _ _ / _ _ _ _		
Address					
City		State		Zip	
Home Ph.		Cell Ph.		Work Ph.	
Email				Add to mailing list?	☐ Yes ☐ No
Employer/School name					
Occupation					
How did you hear about us?					
Have you had massage/bodywork before?	☐ Yes ☐ No				

Emergency Contact

First & Last Name				Relationship	
Home Ph.		Work Ph.		Cell Ph.	

Patient Personal Health History

What results would you like to receive from massage?

Current diagnosed conditions:

Past Significant Health Problems (injuries, surgeries, accidents, etc)

List known allergies:

What medications are you currently taking and for which conditions?(attach a separate sheet if necessary)

Are you taking aspirin, warfarin (Coumadin) or heparin-containing medications? ☐ Yes ☐ No

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Please take a moment to read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Do you suffer from?	Year/ Age	Currently	Past	Never
ALLERGY - TO NUT OILS		☐	☐	☐
Hepatitis		☐	☐	☐
HIV/AIDS		☐	☐	☐
Cancer		☐	☐	☐
Chemotherapy		☐	☐	☐
Blood clot		☐	☐	☐
Diabetes		☐	☐	☐
Heart attack		☐	☐	☐
Stroke		☐	☐	☐
Pacemaker		☐	☐	☐
High blood pressure		☐	☐	☐
Low blood pressure		☐	☐	☐
Swelling		☐	☐	☐

Do you suffer from?	Year/ Age	Currently	Past	Never
Surgery in last year		☐	☐	☐
Varicose veins		☐	☐	☐
Drug abuse		☐	☐	☐
MS Multiple sclerosis		☐	☐	☐
Headaches/Migraines		☐	☐	☐
Fibromyalgia		☐	☐	☐
Skin condition		☐	☐	☐
Arthritis		☐	☐	☐
Osteoporosis		☐	☐	☐
Thrombosis/Phlebitis		☐	☐	☐
Motor vehicle accidents		☐	☐	☐
Are you pregnant? Due date:		☐ Yes	☐ No	

Informed consent

I understand that the massage/bodywork treatment I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the practitioner so that the treatment, pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork 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 of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, or prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed 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 fail to do so. I shall refrain from the use of mind-altering drugs, alcohol, or intoxicants prior to or during sessions. I also understand 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. Services provided are strictly non-sexual.

- Cupping involves a localized suction produced by using rubber/silicone cups. There is a possibility that local bruising is likely to occur at the site where Gua Sha is performed.
- Although we strive to provide massage services to as many people as possible, without prejudice, we reserve the right to refuse treatment to anyone. This includes but is not limited to those persons requesting services outside of the therapist's expertise or scope of practice.
- Scheduled sessions must be canceled at least 24 hours prior to the appointment to avoid being charged for a full session. The charge is waived if the appointment is rescheduled to another time. True emergencies will be considered.
- I understand that payment is due at the time of service
- Medical Records and medical claims: I authorize the release of any medical or other information necessary to process my medical claims to my insurance plan. I authorize payment of medical benefits to the above mentioned physician and understand that I am responsible for the payment of any co-pay, co-insurance, deductible, or any services not covered by my insurance plan.

Your name: _____ Signature: X _____ Date _____