



PATIENT INITIAL PAPERWORK

GENERAL INFORMATION:

NAME: _____ AGE: _____ SEX: M / F

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: _____

EMAIL ADDRESS: _____

REFERRED BY: Friend Company Other: _____

PAYMENT OPTION: Free Company Paid Session Keep Card on File Paypal Invoice

HISTORY:

Have you had chair massages before? YES / NO

Have you had any recent injuries? YES / NO _____

Have you had any recent surgeries? YES / NO _____

List any other health conditions not mentioned: _____

TREATMENT: Please check areas you experience pain, tension and/or tightness.

- Neck Headaches Shoulders Arms and/or Hands
 Upper/Mid Back Lower Back Hips/SI Region Legs and/or Feet

HIPPA & CONSENT FOR CARE:

I give the therapists authority to care for me in accordance with testing, diagnosis, analysis and treatment. I am responsible to inform you of any symptoms, conditions, or issues which would otherwise not come to their attention.

I acknowledge and agree to the following HIPPA policies:

1. The privacy notice is available to me now and at any time in the future.
2. Appointment reminders may be used by the practice via email, text, phone or mail.
3. I understand that if I revoke this consent the practice has the right to refuse treatment.
4. I authorize the release of my medical information to: _____

Patient Signature: _____ Date: _____