

First Name \_\_\_\_\_

Date of birth \_\_\_\_\_

Last Name \_\_\_\_\_

Referred by \_\_\_\_\_

Email Address \_\_\_\_\_

Mobile Phone # \_\_\_\_\_

Home Phone # \_\_\_\_\_

Work Phone # \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

Emergency contact name \_\_\_\_\_

Physician's name \_\_\_\_\_

Emergency contact relationship \_\_\_\_\_

Physician's phone # \_\_\_\_\_

Emergency phone # \_\_\_\_\_

Date of initial visit \_\_\_\_\_

How would you rate your general health?

- Excellent
- Good
- Fair
- Poor

Have you had a professional massage before?

- Yes (Date of last treatment) \_\_\_\_\_
- No

List current medications & the conditions they are treating

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List any major accidents or surgeries (including dates)

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Please tell us about any allergies or hypersensitivities

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Reason for initial visit

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**HEAD NECK**

- Headaches / migraines       Vertigo / dizziness
- Ringing in ears                 Hearing loss
- Vision problems                 Vision loss

**RESPIRATORY**

- Asthma                               Shortness of breath
- Chronic cough                   Bronchitis
- Emphysema                       Sinusitis
- Frequent colds                  Smoker
- Family history of respiratory difficulties

**NERVOUS SYSTEM**

- Sensory loss / change         Numbness / tingling
- Sciatica                             Epilepsy
- Seizures                           Multiple sclerosis

**MUSCULOSKELETAL SYSTEM**

- Arthritis                           Family history of arthritis
- Osteoporosis                   Tendonitis
- Bursitis                           Jaw pain (TMJ)
- Pins / plates / wires / artificial joint

**REPRODUCTIVE**

- Pregnant                          Given birth
- Gynecological problems

**CARDIOVASCULAR**

- High blood pressure             Low blood pressure
- Heart attack                       Stroke
- Heart disease                    Poor circulation
- Phlebitis / varicose veins     Pacemaker
- Hemophilia
- Chronic congestive heart failure
- Family history of cardiovascular problems

**SKIN & INFECTIONS**

- Hepatitis                          HIV / AIDS
- Herpes                              Tuberculosis
- Lyme disease                    Infectious skin conditions

**OTHER CONDITIONS**

- Cancer                             Diabetes
- Unexplained weight loss       Digestive conditions
- Fibromyalgia                    Chronic fatigue syndrome
- Depression                       Anxiety
- Psychiatric disorder
- Other conditions \_\_\_\_\_

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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 my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Douglasville Therapeutic Massage  
8697 Hospital Drive  
Suite 202  
Douglasville, GA 30134

Cancellation / No Show Policy

Due to the recent rise in late cancellations and no shows we are enforcing our policy.

The policy is as follows:

If you cancel your appointment at least 24 hours before the scheduled time, there will be no fee.

If you cancel your appointment LESS than 24 hours before the scheduled time, there will be a \$45.00 fee.

If you cancel your appointment LESS than 12 hours before the scheduled time, there will be a fee that is the cost of your full session.

**\*\* No Call or No Show will be charged the Full Session Price \*\***

If WE have to cancel and give you LESS than 24 hour's notice, you will receive 50% OFF of your next visit.

We hope that this will never happen, but illnesses and emergencies are a part of everyday life. Exceptions will be considered on a case by case basis.

Thank you for your understanding and continued support.

Print your name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

By signing this you agree to the terms stated above