



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Your e-mail address will not be sold or given to any third party.

How would you like your appointments confirmed? Text\_\_ Call\_\_ Email\_\_

Occupation: \_\_\_\_\_

Emergency Contact & Phone: \_\_\_\_\_

Primary reason for this appointment? \_\_\_\_\_

How did you hear about Natural Therapy Wellness Center? Please check one.

Google\_\_ Yelp\_\_ Phone Book\_\_ Facebook\_\_ Gift Certificate\_\_  
Other \_\_\_\_\_

Friend Referral (if so, please specify who) \_\_\_\_\_

**Circle correct response**

**Explain**

Have you ever received a professional massage? Yes No \_\_\_\_\_

Do you have skin allergies conditions? Or Open wounds? Yes No \_\_\_\_\_

Do you exercise regularly? Yes No \_\_\_\_\_

Have you had any recent surgeries or traumas? Yes No \_\_\_\_\_

Do you have any heart conditions? Yes No \_\_\_\_\_

Do you have either high or low blood pressure? Which? Yes No \_\_\_\_\_

Do you have varicose veins, blood clots, aneurysms or  
any circulatory problems? Yes No \_\_\_\_\_

Do you have Diabetes? Yes No \_\_\_\_\_

**Please Turn Over**

Do you bruise easily or sensitive to touch? Yes No \_\_\_\_\_

Do you experience dizziness? Yes No \_\_\_\_\_

Do you experience migraines or frequent tension headaches? Yes No \_\_\_\_\_

Do you have arthritis? If so, where is it located? Yes No \_\_\_\_\_

Do you have any spinal problems? Yes No \_\_\_\_\_

Do you have an infection or contagious disease? Yes No \_\_\_\_\_

Are you pregnant? Due Date \_\_\_\_\_ Yes No \_\_\_\_\_

**Are you able to go up/ down stairs?** Yes No \_\_\_\_\_

Do you have, or ever had a history of any of the following? (Please circle all that apply)

Asthma

Cancer

Insomnia

Digestive Problems

Please list any other medical conditions or current treatments and medications:

Is there anything else you think we would need to know before receiving massage therapy?

I understand that the Session is for the purpose of stress reduction; relief from muscular tension or spasm, and/or for increased circulation and energy flow and hereby give my consent for the therapy. I understand that the therapists do not diagnose illness, disease or other physical or mental disorders and do not prescribe medical treatment or pharmaceuticals, nor do they perform any bone and/or spinal manipulations. I understand that the therapy is not a substitute for medical examination or diagnosis and that I should see a physician for any physical ailment that I may have. I have stated all my known medical conditions and agree to keep the staff informed of all changes to my medical condition or physical health before any future treatments. I give permission to be contacted by telephone, text or e-mail by Natural Therapy Wellness Center Inc.

### **Cancellation Policy**

Any cancellations with less than 24 hours of notice are subject to a cancellation fee of 50% of the normal session charge. Clients who miss their appointments without giving any notification may be charged in full for the scheduled service. We recognize the time of our clients and staff is valuable and have implemented this policy for this reason.

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Parent Signature (if under age 18) \_\_\_\_\_ Today's Date: \_\_\_\_\_