Massage Health & Healing *Energies*, LLC

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Confidential Health Questionnaire

Email: _____

Client Name: _____ Today's Date: _____
Street Address: _____ Date of Birth: _____
City: _____ State: _____ Zip Code: _____
Occupation: _____ Age: _____ Height: _____ ____ Weight: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Have you ever received Massage Therapy before? If so, when? _____
What is the reason for your visit today? _____
Is there any area where you would like extra time spent; any area where you have muscle soreness, stiffness or tension? _____ Are you currently in pain? _____ Where? _____
Daily Activities/Sports/Hobbies/Exercise: _____
Posture assumed most of the day: _____ Daily Water Intake: _____
Daily caffeine intake: _____ Average hours sleep per night: _____
Known allergies (Lotion/Oil/Nuts) _____
Do you consume any of the following?

□ Tobacco
□ Alcohol
□ Illegal Substances
□ Vitamins (Please specify); _____
□ Herb Supplements (Please specify); _____
□ Over the counter Meds (Tylenol, Advil, allergy, etc. Please specify); _____

Are you currently taking any prescription medication: (Name & dosage): _____

_____

Do you have a Physician referral/prescription? _____ Are you seeking insurance reimbursement? _____

Medical History (Please indicate below any significant medical problems and such conditions that could influence the type or depth of work done in any given area.)

□ Skin condition (acne, rash, allergies, skin cancer, abscess, open sores) Other: _____
□ Lymphatic condition (swollen glands, lymphoma, lymph edema) Other: _____
□ Recent injury or accident (Whiplash, sprain, deep bruise) Other: _____
□ Circulatory condition (Heart disease, varicose veins, phlebitis, arrhythmia, arteriosclerosis) Other: _____
□ Neurological condition (sciatica, numbness/tingling of any area of skin, stroke, epilepsy, carpal tunnel) Other: _____
□ Joint problems (osteoarthritis, rheumatoid arthritis, gout, hyper mobile joints, sacroiliac problems, disc) Other: _____
□ Bone conditions (osteoporosis, previous fracture, cancer) Other: _____
□ Headaches (migraines, PMS, tension, cluster) Other: _____
□ Emotional difficulties (depression, anxiety, psychotic episodes) Other: _____
□ Stress related disorders (stomach ulcers, PTSD) Other: _____
□ Previous surgery (Please state type and date) _____
□ Other medical considerations _____
□ Do you use any of the following: (contacts, dentures, hearing aids, pins, pacemaker) _____
□ Blood condition (hemophilia, HIV, Hepatitis A, B, C, D, E) Other: _____
□ Diabetes □ Asthma □ Dizziness □Are you Pregnant □ Blood Pressure (high, low)
Are you under medical care or supervision: _____ For what condition? _____
Have you ever received Chiropractic care: _____ For what condition? _____
Do I have consent to contact your Health Care Provider or Chiropractor for consultation if needed? _____
Health Care Provider, i.e., DR., PA, ARPN: _____ Phone Number: _____
Name of Chiropractor: _____ Phone Number: _____

Signature: _____ Date: _____

Payment/Cancellation Policy

Payment in Full is required at the time of appointment. Cash, Check, Credit Cards are acceptable methods of payment.

Rates:

Therapeutic Massage:
60 Minute: $75.00
90 Minute: $95.00 (Includes Deep Tissue and Energy)
30 Minute: $50.00 (Specific Work / Deep Tissue and/or Energy)

Pre-Paid Packages: 60 Minute Sessions: 3 for $210.00: 5 for $325.00:
90 Minute Sessions: 3 for $270.00: 5 for $425.00:

Chair Massage: $35 set up fee and $1 per minute per therapist.

Manual Lymph Drainage: Treatment Options:
Initial 5 Treatments - $450.00
Subsequent 5 Treatments - $400.00

Specific Area Treatments:

30 Minute Treatment - $ 50.00
60 Minute Treatment - $ 100.00
90 Minute Treatment - $150.00

Full Body Energy Session: 60 Minutes: $75.00
Pre-Paid: 3 for $210.00: 5 for $325.00:

Any client who is late for an appointment will be charged for the full session, and the session will end at the regularly scheduled time. In the event the client is unable to attend the scheduled session, 24-hour notice must be given to the Practitioner. The session can be rescheduled. If a client fails to cancel an appointment within 24 hours multiple times, they will be asked to pre-pay for future services.

Confidentiality Policy

All written records and verbal communications will be kept confidential and secured unless a client information release form has been signed, by the client, and submitted, by a requesting agency, to the Massage Therapist.
In the event that a client is diagnosed with HIV, and has disclosed this information to the Massage Therapist, this information will be kept locked and secured on the premises, or destroyed, in the manner currently dictated by law.

Consent for Care

It is my choice to receive Massage Therapy. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my comfort level. 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 or 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 Massage Therapist of any changes in my health status.

I understand and accept the above described "MHHE Policies and Procedures" and I give my consent to receive care.

Signature: _____ Date: _____

All of MHH*E*'s Policies and Procedures can be reviewed and downloaded from our website:
www.MassageHealthHE.com/resources. "Massage Health & Healing *Energies*, LLC Policies and Procedures"