Max Wellness Massage

Personal Information:

Name:_____DOB:_____Phone:_____

Address:_____City:_____State:_____Zip:_____

Email:_____ Contact via: Call Text Email

Occupation:_____Emergency#:_____Relation:_____

Massage Information:

Preferred pressure? Light- 1 2 3 4 5 6 7 8 9 10 -Firm

What do you look for in massage? Relaxation Pain Relief

Have you had a professional massage?
Y N

How Often?_____

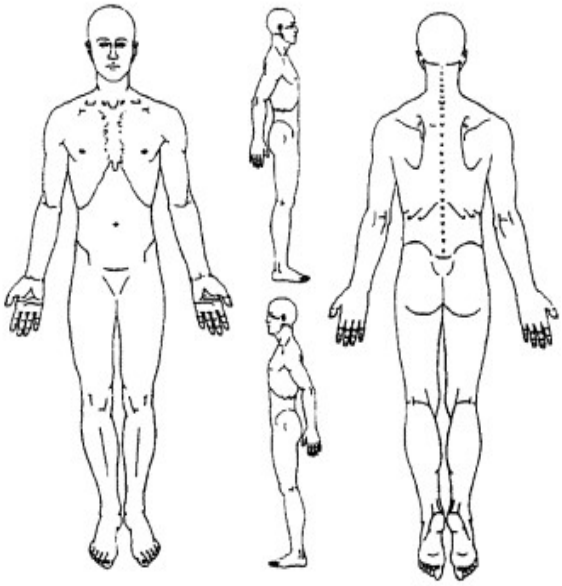
Last massage?_____

Common areas of pain/tension?_____

_____

Goals:_____

_____



Please indicate any areas that you would like/dislike massage→

Medical History

Do you exercise regularly? Y N

_____

Chronic pain? Y N How long?_____

What makes pain more or less symptomatic? _____

Are you currently under medical care? Y N Dr._____Rx?_____

Accidents/Injuries/Year_____CHF?_____

Surgeries/Year_____

Headaches? Y N _____ Blood Pressure? Good High Low Blood Clots? Y N

Pregnant? Y N_____ Do you like using essential oils? Y N Sensitive Skin? Y N

Skin
Conditions?_____Numbness?_____

How did you hear about MaxWellness Massage?_____

Are you interested in maintenance massage? Y N _____

Agreement I understand that the massage I will be receiving here is for the purpose of stress and pain reduction. I understand that the massage therapist does not diagnose illness, disease, or any further physical or mental disorders. I understand that it is my responsibility to inform the massage therapist of any changes to this information. I understand that if I experience unusual discomfort and/or pain during my massage sessions it is my responsibility to inform the massage therapist so that they can adjust the pressure or technique being used.

Privacy Policy All written records and massage sessions are kept strictly confidential and will not be shared with any outside establishment, individuals, organizations, or medical facilities without explicit written consent from the client or client's legal guardian unless legally required by local, state or federal subpoena, summons, or other court order.

Payment/Cancellation Policies
In fairness to our patients and to us, 24-hour notice is required for cancellation of an appointment, or you will be charged in full for the appointment. We do not bill your insurance company for missed appointments or late cancellations; you are responsible. Payment is due before your next appointment.

Signature_____Date_____

LMT/MMP
Signature_____

Notes: