BackBone
WELLNESS CENTER

Name:_____Date of Birth: _____ Date:_____

Address:_____ City/State/Zip:_____

Phone: Cell: _____ Work:_____ Email:_____

Please circle if you would like to receive **TEXT** or **EMAIL** reminders (circle one).

If you prefer TEXT please list your carrier:_____

Would you like to receive our promotional emails **YES** or **NO** (please circle).

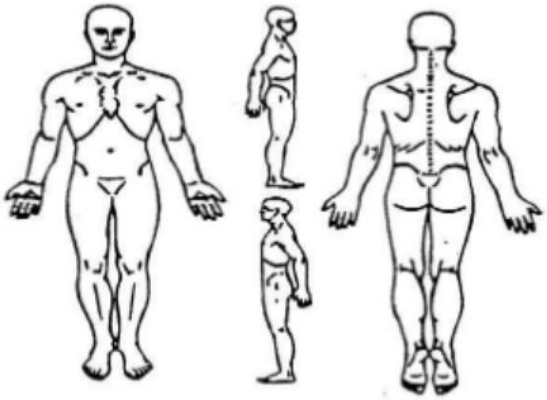
Occupation:_____ Height:_____ Weight: _____

Emergency contact name and phone number : _____

Referred by:_____

Are you currently in pain or experiencing any discomfort? If so, please briefly explain and indicate those areas below:

_____



Describe any chronic pain/tension:_____

What makes it better?_____What makes it worse?_____

Are you currently under the care of a physician, chiropractor, acupuncturist or other provider?_____

If yes, what are you being treated for?_____

Please list any medications, vitamins or supplements you are currently taking:_____

If so, what for?_____

What specific areas would you like me to focus on?_____

Are there any areas you would like me to stay away from?_____

Are there any areas you do NOT like massaged? (i.e. feet, stomach, pelvis, glutes, groin, head, face)?_____

What do you hope to accomplish with this massage? (relaxation, decrease back pain, increase flexibility, etc.)_____

Do you have any problems or allergies to any oils/lotions? **YES NO UNKNOWN** If known which ones?_____

Do you have any past or current medical conditions or injuries? _____

Do you have varicose veins or blood clots? **YES NO** _____

Women-Are you currently pregnant? **YES NO** If yes, approx. due date:_____

- If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my comfort level.
- I understand that the treatment here is not the replacement for medical care.
- As such, the therapist does not prescribe pharmaceuticals, nor does he or she perform any spinal manipulations.
- I understand that if I am uncomfortable at any time, I will ask the therapist to stop and my session will end. If my therapist is uncomfortable at any time, he or she will stop as well.
- I understand that the treatment is not a substitute for medical treatments and or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions I may have.
- I have stated all my known medical conditions and take it upon myself to keep the therapist updated on my health.
- I understand that payment is due at the time of service unless other arrangements have been made.
- **I agree to give at least 24 hours notice of cancellation of appointment, otherwise I will be expected to pay $25 for the session. PLEASE INITIAL _____**

Client Signature:_____ Date: _____

MINOR INFORMED CONSENT

I, _____, am the parent or guardian having legal custody of
Parent or legal guardian
_____. I hereby authorize _____,
Minor client *Massage therapist*
To administer treatment. I verify that the minor client is of sufficient age and aptitude as to provide verbal and written feedback to the therapist before, during and after the massage. I understand that I am welcome and encouraged to remain in the area where the massage is being administered. I further understand that as the parent/legal guardian, I have the right to place andy conditions on the environment and massage on behalf of the minor.

Signature:_____ Date:_____
Parent or legal guardian Authorized Adult Consent

Massge therapist signature_____ Date:_____