

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_ DOB \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Referred by: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
In case of emergency: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Occupation \_\_\_\_\_ \_ Male \_ Female Physician \_\_\_\_\_

**Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.**

- Have you ever experienced a professional massage or bodywork session? \_ Yes \_ No How recently? \_\_\_\_\_
- What are your massage or bodywork goals? \_\_\_\_\_
- What kind of pressure do you prefer? \_ light \_ medium \_ firm
- What type of cream do you prefer? \_ scented \_ unscented
- Are you receiving massage to reduce pain or other issues related to a recent accident (vehicular/work related/other)? \_ Yes \_ No
- If the answer to the question above is yes, then an additional charge in the amount of \$\_\_\_\_\_ will be added to your total to cover the time and effort required to document your condition and progress, as insurance companies/courts often require complete documentation of your treatment history, sometimes months later. Do you understand and agree to this additional charge? \_ Yes \_ No

***If you answer "yes" to any of the following questions, please explain as clearly as possible.***

- |   |   |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you frequently suffer from stress?          | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you bruise easily?                                      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have diabetes?                          | <input type="checkbox"/> Yes <input type="checkbox"/> No Any broken bones in the past two years?                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience frequent headaches?          | <input type="checkbox"/> Yes <input type="checkbox"/> No Any injuries in the past two years?                        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant?                              | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have tension or soreness in a specific area?        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from arthritis?                  | Please specify _____  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing contact lenses?                | _____   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing dentures?                      | _____   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high blood pressure?               | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have cardiac or circulatory problems?               |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking high blood pressure medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from back pain?                              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from epilepsy or seizures?       | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have numbness or stabbing pains?                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from joint swelling?             | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you sensitive to touch or pressure in any area?        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have varicose veins?                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? Explain below.                  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any contagious diseases?           | <input type="checkbox"/> Yes <input type="checkbox"/> No Other medical condition, or are you taking any             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have osteoporosis?                      | medications I should know about?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any allergies?                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have warts or other skin conditions? Explain below. |

Are you currently experiencing: \_\_\_\_\_ Cold/Flu \_\_\_\_\_ Inflammation \_\_\_\_\_ Fever \_\_\_\_\_ Infection \_\_\_\_\_ Contagious Disease

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please initial the following statements if you understand and agree to abide by them.**

\_\_\_\_ I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

\_\_\_\_ I understand that this massage is for my benefit, not the massage therapist's. My therapist's goal is to provide me with an enjoyable and therapeutic experience so that I will want to return. Therefore, my therapist will gratefully welcome any requests or comments I make, such as needing a blanket, requesting quiet, or more/less pressure, and my therapist absolutely will not be offended by such requests.

\_\_\_\_ I understand that I have the right to discontinue my massage at any point, and I do not need to give a reason. However, I also understand that I may still be charged for the full time allotted for my scheduled appointment.

\_\_\_\_ I understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware.

\_\_\_\_ I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

\_\_\_\_ I understand that there is no implied or stated guarantee of success or effectiveness for massage/bodywork sessions. It is my choice to receive massage/bodywork and I give my consent for massage/bodywork.

\_\_\_\_ I understand the dangers of obtaining a massage that could result from complications which include and may be related to, but are not limited to, health problems as stated on the completed medical form.

\_\_\_\_ Because massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly.

\_\_\_\_ I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

\_\_\_\_ I understand that I may incur complications as a result of my participation in massage therapy with Kimberly Elkins/Kettering Therapeutic Massage. I hereby release and forever discharge Kettering Therapeutic Massage, Kimberly Elkins, and its employees, officers, and agents from any liability now or in the future arising from my participation in this massage therapy program.

\_\_\_\_ I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

\_\_\_\_ I have read and understand the cancellation/late arrival/returned check policy. If you have not seen it, please ask to see it before initialing.

Client Name \_\_\_\_\_ Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Practitioner Signature \_\_\_\_\_ Date \_\_\_\_\_

***Consent to Treatment of Minor:***

By my signature below, I hereby authorize **Kimberly Elkins, LMT** to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

## **Cancellation/no-show/late arrival/returned check policy**

I understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, snowstorms, and illness are just a few reasons why one might consider canceling an appointment. In my desire to be effective and fair to all of my clients and out of consideration for my time and theirs, I have adopted the following policies:

### **Cancellations**

- 24 hour advance notice is required when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment.
- If you are unable to give me 24 hours advance notice you will be charged the full amount of your appointment. This amount must be paid within three business days to avoid collection activity.
- Many customers ask, "Why do you have to charge me? It's just an hour of your day." In response, I tell them that for a one hour appointment, I set aside 75 to 90 minutes for the appointment, and I typically can physically handle 4 or 5 customers in a day. In expectation of their appointment, I have often turned away other customers for that time slot. If the scheduled client does not come for their appointment and I have no notice, then I cannot fill that slot and I have lost between 20-25% of my income for the day. Although most clients are extremely considerate of my time, there are always a few who are not, which is why I must institute this policy.

### **No-shows**

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show". They will be charged the full amount for their "missed" appointment and future service will be denied until payment is made. This amount must be paid within three business days to avoid collection activity.

### **Arriving late**

Appointment times have been arranged specifically for you. If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Unless you have spoken with me and I tell you otherwise, if you are more than 20 minutes late, it will be assumed that you are a no-show and you will then be responsible for payment of the full session. Regardless of the length of the treatment actually given, you will be responsible for the "full" session.

Out of respect and consideration to your therapist and other customers, please plan accordingly and be on time.

### **Returned Checks**

If a check is returned for non-sufficient funds, I will charge you a \$20 fee in addition to the amount of the bounced check. This full amount must be paid within 3 business days, in cash or via Paypal. If you do not pay, the account may be sent to collections. No further appointments will be accepted until the full amount is paid.