

Peace of Mind Massage, INC

Patient Agreement Form

Please be aware that your massage time will not begin until you are on the table receiving your massage. Please notify your Therapist if you have to be done by a certain time. This does not apply if you are late.

Payment can be accepted in the form of cash, check, or Mastercard/Visa/American Express. Payment is expected at the end of your appointment unless pre-paid via gift certificate or package.

Cancellation Policy: 24 hours notice of cancellation or the Therapist may bill you if the time slot could not be filled.

The Therapist has the right to refuse treatment to any client if massage would be contradictive to their health or if the client exhibits inappropriate behavior.

I, \_\_\_\_\_, voluntarily request and consent to receive Massage Therapy and Bodywork including Hydrotherapy, Stretching, and suggested home care from Peace of Mind Massage, INC.

Sign and date if you understand and agree to the policies given by Peace of Mind Massage, INC.

\_\_\_\_\_  
Sign

\_\_\_\_\_  
Date

# Peace of Mind Massage, INC.

## Confidential Intake Form

Name \_\_\_\_\_

Date \_\_\_\_\_

E-mail \_\_\_\_\_

Address \_\_\_\_\_

Street

City

State

Zipcode

Home Number \_\_\_\_\_ Cell Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Are you presently taking any medications or herbs? No

Yes \_\_\_\_\_

Have you had a recent major surgical procedure or injury? No

Yes \_\_\_\_\_

Have you had a professional massage before? Yes No

Please circle your stress level:

What kind of pressure do you prefer?

Low 1 2 3 4 5 High

Light

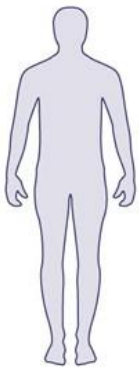
Medium

Firm

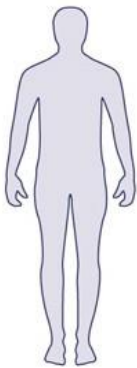
Are you allergic to any Lotions or Oils? No

Yes \_\_\_\_\_

Note: We use Biotone Hypoallergenic Sensitive Skin Lotions and Creams.



FRONT



BACK

Circle the areas on the body you are experiencing pain or soreness.

Please list any areas you do not wish to be treated \_\_\_\_\_-

Please list your physical activities \_\_\_\_\_

Are you pregnant? If yes, how many weeks \_\_\_\_\_

Have you recently been in an Auto Accident? If yes, when? Did you see a doctor? What was the diagnosis? \_\_\_\_\_

Circle the following conditions that apply to you, past and present:

Musculo-Skeletal

Headaches  
Joint stiffness/swelling  
Spasms/cramps  
Broken/Fractured bones  
Strains/Sprains  
Back, hip pain  
Shoulder, neck, arm, hand pain  
Leg, foot pain  
Chest, ribs, abdominal pain  
Problems walking  
Jaw pain/TMJ  
Tendonitis  
Bursitis  
Arthritis  
Osteoporosis  
Scoliosis  
Other: \_\_\_\_\_

Circulator/Respiratory

Dizziness  
Shortness of breath  
Fainting  
Cold feet or hands  
Cold sweats  
Stroke  
Heart condition  
Allergies  
Asthma  
High blood pressure  
Low blood pressure  
Other: \_\_\_\_\_

Digestive

Indigestion  
Constipation  
Intestinal gas/bloating  
Diarrhea  
Irritable bowel syndrome  
Crohn's Disease  
Colitis  
Other: \_\_\_\_\_

Nervous System

Numbness/tingling  
Fatigue  
Sleep disorders  
Ulcers  
Paralysis  
Herpes/shingles  
Cerebral Palsy  
Epilepsy  
Chronic Fatigue Syndrome  
Multiple Sclerosis  
Muscular Dystrophy  
Parkinson's Disease  
Other: \_\_\_\_\_

Skin

Rashes  
Allergies  
Athlete's foot  
Acne  
Impetigo  
Hemophilia  
Other \_\_\_\_\_

Other

Depression  
Difficulty concentrating  
Hearing Impaired  
Visually Impaired  
Diabetes  
Fibromyalgia  
Post/Polio Syndrome  
Cancer  
Tuberculosis

Please sign and date if the information you have provided is accurate to the best of your knowledge.

\_\_\_\_\_ Date

\_\_\_\_\_ Patient Signature