

Welcome to
Peace of Mind Therapeutic Massage & Wellness, LLC

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.

Payment can be accepted in the form of cash, check, or Mastercard/Visa. 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 Therapeutic Massage & Wellness, LLC. Sign and date if you understand and agree to the policies given by Peace of Mind Therapeutic Massage & Wellness, LLC.

Sign

Date

Please turn to the next page to fill out a confidential medical intake form. This is required for your Therapist to be well informed on your medical history and health. Please notify your Therapist of any conditions, injuries, or illnesses you are experiencing or any medications you are taking.

Peace of Mind Therapeutic Massage & Wellness, LLC

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

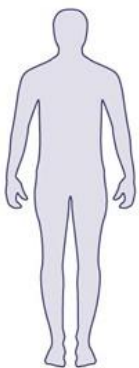
Please circle your stress level:

Low 1 2 3 4 5 High

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:_____

Digestive

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

Skin

- Rashes
- Allergies
- Athlete's foot
- Acne
- Impetigo
- Hemophelia
- 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:_____

Other

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

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:_____

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

Date

Patient Signature