

CASH MASSAGE

Please Print

Last Name _____ Hm Phone _____
 First Name _____ M.I. _____ Wk Phone _____
 Mailing Address _____ Cell Phone _____
 City _____ State _____ Zip _____ Email Address _____
 Occupation/Activities _____ Date of Birth ____/____/____ Age ____ M ____ F ____
 Why are you here today for a massage today? _____
 How did you learn about us? _____

HEALTH HISTORY

Mark any condition that applies to you now or in the past. Please use 'C' for current, 'P' for past

<input type="checkbox"/> Allergy to Nut Oils	<input type="checkbox"/> Cancer/Tumor	<input type="checkbox"/> Headaches / Migraines	<input type="checkbox"/> Muscle Sprain/Strain
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Contact Lens	<input type="checkbox"/> Heart Attack / Stroke	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Contagious Conditions	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Decreased Sensation/Numb	<input type="checkbox"/> Hypo or Hyperglycemia	<input type="checkbox"/> Skin Infections
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Other _____

Other relevant health history? _____

Accidents, Injuries or Surgeries:

Less than 5 years ago _____

More than 5 years ago _____

Are you currently receiving medical or chiropractic care? Yes ____ No ____

If yes, please explain _____

Are you taking any medications (prescription & over-the-counter)? Yes ____ No ____

If yes, please explain _____

Exercise? ____ What type? _____ How often? _____

Have you received massage before? Yes ____ No ____

Please read and initial:

____ Payment is due at the time of service.

____ A \$15.00 billing fee is charged for payment not made at time of service.

____ MTM charges \$25.00, plus bank fees for all returned checks.

____ A \$25 hold will be placed on your credit card to reserve an appointment. **If the appointment is missed or cancelled without a 24-hour notice, you will be charged the \$25 fee.**

____ An unpaid balance is due 30 days from statement date. Interest of 1.5% or a minimum of \$1.00 per month will be charged until the balance due is paid. Rebilling fees may be added. Additional court, attorney or collection agency fees may be charged, up to 50%, if applicable.

____ Massage therapists do not diagnose illness or disease, or prescribe treatments.

____ All information provided is complete and accurate; I will notify MTM of any changes. Any changes in my physical condition will be told to my treating LMP prior to my treatment.

____ We reserve the right to change the terms and conditions at any time.

____ I have been given or offered and read the privacy/HIPAA information for MTM.

____ In an emergency, call immediately to reschedule.

Patient/Guardian Signature _____ Date _____