



Holistic Health Clinic

4670 SW Washington Ave.

Beaverton, OR 97005

## Confidential Client Health Information for Massage Therapy

Name \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_ DOB \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact # \_\_\_\_\_ Contact Name & relation \_\_\_\_\_

Referred By \_\_\_\_\_ Have you ever had a massage before? \_\_\_\_\_

Purpose for today's massage \_\_\_\_\_

List any medications you are taking: \_\_\_\_\_

Please check if you have any of the following conditions:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Recent Injury   | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Varicose Veins           |
| <input type="checkbox"/> Recent Illness  | <input type="checkbox"/> Kidney Problems     | <input type="checkbox"/> Blood Clots              |
| <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Recent Surgery      | <input type="checkbox"/> Allergies to Scents/Oils |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> Pregnancy           | <input type="checkbox"/> Skin Condition           |
| <input type="checkbox"/> Phlebitis       | <input type="checkbox"/> Wear Contact Lenses | <input type="checkbox"/> High/Low Blood Pressure  |
| <input type="checkbox"/> Other _____     |  |   |

Please explain above \_\_\_\_\_

Are you currently under a doctor's care for any of the conditions above? \_\_\_\_\_

Name of Physician \_\_\_\_\_ Phone # \_\_\_\_\_

**PRIVACY POLICY:** Due to HIPAA Privacy Regulations, our office is required to offer you a notice of our privacy practices. This document lets you know what steps we take in protecting your health information. Please ask the front office staff if you would like a copy.

\_\_\_\_\_ Do not want a copy      \_\_\_\_\_ Received a copy

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

### CANCELLATION POLICY

To avoid being charged a \$45 cancellation fee, I agree to give 24 hours notice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## H.H.C. APPOINTMENT CONFIRMATION

Due to the number of missed appointments and/or late cancellations, our office has implemented a mandatory 24 hr. cancellation policy. If you are not able to give 24 hours notice to cancel/reschedule your appointment and we are unable to fill the time slot you will be charged a \$45 fee.

We are requesting that you reserve all future appointments with a Visa or M/C credit or debit card and that you are aware your card will be automatically charged if you do not give the required notice.

Card #	Exp. Date
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Name as written on card

Type of card MC VISA DISCOVER AMEX

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## **MASSAGE CONSENT FORM**

I have been advised of the policies and procedures pertaining to massage and I understand these policies. The massage procedures, information about massage in general, benefits and contraindications of massage, and possible alternative therapies have been explained to me.

I understand that the massage I receive is for the purpose of stress reduction and relief of muscular tension, spasm, or pain, and to increase circulation. If I experience any pain or discomfort, I will immediately inform the therapist so that the pressure or methods used can be adjusted to my comfort level. I understand that massage therapists do not diagnose illness or disease, nor do they perform spinal manipulations or prescribe any medical treatments, and nothing said or done during the session should be construed as such. I acknowledge that massage is not a substitute for medical examination or diagnosis, and I should see a health care provider for those services. Because massage should not be performed under some circumstances, I agree to keep the massage therapist updated as to any changes in my health, and I release the massage therapist and Holistic Health Clinic from any liability if I fail to do so.

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date**

### **Consent to Treat a Minor:**

I \_\_\_\_\_ parent/guardian of \_\_\_\_\_ have read and understood the statements regarding massage therapy. By my signature, I authorize a Holistic Health Clinic massage therapist to provide massage treatments and bodywork to my child or dependent.

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