The Center for Family Wellness

Massage Therapy

Alyssa Johnson, LMT #3994

General Information

Date: ___________________

Patient's Name: ____________________________________ Date of Birth:___________________

Address: _________________________ City: _______________ State: ___________ Zip:____________

Home Phone: _________________ Work Phone: ________________ Cell Phone: _________________

Preferred Contact Number: □ Home □ Work □ Cell Email: _______________________________

Sex: □ Female □ Male Number of Children: _______________

Employer Name: _______________________________ Phone: _______________________

Emergency Contact: ____________________________ Phone: _______________________

Relationship to Contact: ______________________________________

How did you hear about our office: ____

Informed Consent

I understand that Massage Therapists are not Medical Practitioners. They do not diagnose illness or prescribe treatments for disease symptoms. Massage Therapists facilitate stress reduction and assist me in becoming more aware of ways in which I can improve my own health. I understand that if I have a specific health concern or if the therapist notes a specific abnormality it may be recommended that I make an appointment with Dr. Omenski for a formal Chiropractic examination or referral to another physician or specialist.

Signature: ____ Date: __________________________

Consent for Minor

Consent to treatment of Minor: By my signature below, I hereby authorize ***Alyssa Johnson, LMT #3994*** to administer massage, bodywork or somatic therapy techniques to my child or dependent as she deems necessary.

Signature: ____ Date: __________________________

Office Policy

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. Payment is expected at the time of service unless definite financial arrangements are made in advance.

I understand that I am responsible for giving 24 hours' notice to cancel or reschedule my appointment. If not, payment will be expected for the missed appointment.

Patient Signature: ___________________________________ Date: ____________________________

Massage History

Have you had a professional massage before? □ Yes □ No
If yes, how often do you receive massage therapy? ____
Do you have any difficulty lying on your front, back or sides? □ Yes □ No
If yes, please explain: ____
Do you have any allergies to oils, lotions or ointments? □ Yes □ No
If yes, please explain: ____
Do you have any other allergies? □ Yes □ No
If yes, please explain: ____
Do you have sensitive skin? □ Yes □ No
Do you sit for long hours at a workstation, computer or driving? □ Yes □ No
If yes, please explain: ____
Do you perform any repetitive movement in your work, sports or hobby? □ Yes □ No
If yes, please explain: ____
Do you experience stress in your work, family or other aspects of your life? □ Yes □ No
If yes, how do you think it has affected your health? ____
□ Muscle Tension □ Anxiety □ Insomnia □ Irritability □ Other _______________________
Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?
□ Yes □ No
If yes, please explain: ____
Do you consider these chronic or acute? ____
Is there a particular area that you do not want worked on? □ Yes □ No
If yes, please explain: ____
Do you have any particular goals in mind for this massage session? □ Yes □ No
If yes, please explain: ____

Health History

Are you currently under the care of a physician(s)? □ Yes □ No
If yes, please explain: ____
Name of physician(s): ____
Are you currently under the care of a chiropractor? □ Yes □ No
If yes, please explain: ____
Name of chiropractor: ____
Are you currently taking any medications (prescription, over the counter or supplements)? □ Yes □ No
If yes, please list: ____
Have you had any serious injuries or illnesses? □ Yes □ No
If yes, please explain: ____
Have you had any surgeries? □ Yes □ No
If yes, please explain: ____
Do you exercise or have regular activities? □ Yes □No
If yes, please explain: ____
Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you? ____
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