

KineticWise
Sports & Medical Massage
CO-OP

Please answer the following questions, printing clearly on both sides of this form. The answers will better help us in providing service and will be kept completely confidential.

Name _____ Birth Date _____

Address _____ City _____ Zip _____

Email _____ Cell _____

Occupation _____ Work Phone _____

Sex: F ___ M ___ Prefer Not to Answer ___ Age _____ Height _____ Weight _____

Emergency Contact: Name _____ Phone _____

How did you hear about us? (friend, social media, Google etc) _____

Reason for receiving massage _____

Have you ever received a professional massage? ___Y ___N If yes, how many? _____

What are your goals/expectations for treatment today? _____

Physician's name _____ Phone _____

Are you currently under a physician's care? ___Y ___N If yes, please explain:

Are you pregnant? ___Y ___N If yes, how many months _____

Are you currently taking any medication? ___Y ___N If yes, please list:

Are you aware of existing conditions that may be contraindicated by massage? ___Y ___N

If yes, please explain:

Please list any injuries (including falls/other traumas- car accidents) with age and date of occurrence:

Please list any surgeries and dates:

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Do you have any chronic or acute pain or discomfort? Y___N___

If yes, does this inhibit any specific activities? Y___N___ If yes, how? _____

What activities do you participate in? (e.g., running, gardening, biking, hiking, woodworking)

How often do you partake in these activities? ___Few times/month ___1-2x/week ___3+/week

Please check the appropriate boxes that pertain to you and provide any additional information you believe may be useful:

___Sinuses/Allergies

___Numbness/Tingling

___Skin conditions/Rash

Where_____

___Infectious condition

Where_____

___Area of inflammation

Where_____

___Blood Clots

___Sciatica

___Headaches

___TMJ

___Osteoporosis

___Diabetes

___Shortness of breath

___Seizures/Convulsions

___Dizziness/Fainting

___Varicose veins

___Bruise easily

___Heart condition

___Bursitis

___Arthritis

Where_____

___Chest pain

___High blood pressure

___over_____

___Low blood pressure

___over_____

Would you like to be opted in for text messages reminders about your appointments? Yes No

EACH PRACTITIONER AS A SOLE PROPRIETOR RESERVES THE RIGHT TO REFUSE SERVICE TO ANYONE FOR ANY REASON. In particular, but not restricted to, consumption of intoxicating substances such as drugs or alcohol immediately prior to coming to the massage, abusive behavior to any person at the office, sexual solicitation, inappropriate sexual innuendo or behavior, contagious disease, and unsatisfactory hygiene are understood to be reasons of denial of service. **We have a 24 hour cancellation policy which means you must cancel at least 24 hours in advance or you will be billed for the session.** This will be enforced regardless of receiving appointment confirmation. If you are running late, please inform us. Any tardiness results in shorter session for you. If you are 15 minutes or more late, we will consider it a "no show" and you will be billed for the session. Any time you have been billed for a session, for whatever reason, you may reschedule after the bill has been paid. Payment Agreement: All professional services rendered are charged to the patient and the patient is responsible for all fees regardless of insurance coverage. I acknowledge and understand that all charges for services I receive by my massage therapist(s) are due at the time of service, unless other arrangements have been made in advance. I AGREE NOT TO HOLD THE THERAPIST RESPONSIBLE FOR ANY INJURIES, ACCIDENTS, COMMUNICATION DIFFERENCES, CONFLICTS, OR PHYSICAL ILLNESSES THAT MAY ARISE FROM TREATMENT.

SIGNED _____ DATE _____