Kinetic Wise
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_____Phone_____

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?_____

_____

What are your long term goals? _____

_____

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:

_____

_____

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Please list any surgeries and dates:

_____

_____

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

If yes, does this inhibit any specific activities? Y___N___

What activities do you participate in? (running, gardening, biking, hiking, woodworking etc)

_____

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_____

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 your card on file will be charged for the session. This will be enforced regardless of whether or not you have received a re-confirmation call. 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 your card on file will be charged 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_____