

**Kinetic Wise, LLC.**

**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 \_\_\_\_\_

Reason for receiving massage \_\_\_\_\_

Have you ever received a professional massage? \_\_\_Y \_\_\_N    If yes, how many? \_\_\_\_\_

How did you hear about us (i.e. friend, social media, etc)? \_\_\_\_\_

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 in the past five years:  
\_\_\_\_\_  
\_\_\_\_\_

Please list any surgeries and dates:  
\_\_\_\_\_  
\_\_\_\_\_

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

- |   |   |
|---|---|
| <input type="checkbox"/> Sinuses/Allergies    | <input type="checkbox"/> Shortness of breath  |
| <input type="checkbox"/> Numbness/Tingling    | <input type="checkbox"/> Seizures/Convulsions |
| <input type="checkbox"/> Skin conditions/Rash | <input type="checkbox"/> Dizziness/Fainting   |
| Where _____                                   | <input type="checkbox"/> Varicose veins       |
| <input type="checkbox"/> Infectious condition | <input type="checkbox"/> Bruise easily        |
| Where _____                                   | <input type="checkbox"/> Heart condition      |
| <input type="checkbox"/> Area of inflammation | <input type="checkbox"/> Bursitis             |
| Where _____                                   | <input type="checkbox"/> Arthritis            |
| <input type="checkbox"/> Blood Clots          | Where _____                                   |
| <input type="checkbox"/> Sciatica             | <input type="checkbox"/> Chest pain           |
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> High blood pressure  |
| <input type="checkbox"/> TMJ                  | _____ over _____                              |
| <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Low blood pressure   |
| <input type="checkbox"/> Diabetes             | _____ over _____                              |

**KINETICWISE 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 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 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 \_\_\_\_\_