NEW CLIENT FORM

Welcome! This form was designed to assist me in providing you the best professional care and service. The information you provide on this form and during treatments will be held in the strictes confidence. Thank you for taking the time to fill out this form as accurately and completely as possible.

Date: _____ Referred by: _____

Client's Information

Name: _____

Address: _____

City/ZIP: _____

DOB: _____ Gender: _____

Occupation: _____

Contact Information

Cell: _____

Home: _____

Work: _____

E-Mail: _____

Background Information

Have you ever received a massage: ❑ Yes ❑ No If YES, what type(s): _____

What is your goal for today's massage: _____

Do you have a pressure preference: If YES, please select ❑ Light ❑ Moderate ❑ Firm ❑ Deep

Do you wear any of these: ❑ Contacts ❑ Orthotics ❑ Dentures ❑ Prothesis ❑ Hairpiece/Wig

Areas do you NOT want worked on: ❑ Back ❑ Arms ❑ Legs ❑ Buttocks ❑ Abdomen ❑ Chest ❑ Face ❑ Neck ❑ Head ❑ Feet ❑ Hands ❑ Other _____

List any hobbies, activities, sports or exercis you're currently involved in: _____

_____

What medications are your taking, including self-prescribed: _____

Have you had any operations, accidents, falls or injuries in the past 3 years: _____

(Or anything of signifiance prior to 3 years) _____

Medical History

Do you now have or ever had any of the following:

Headaches ❑ Now ❑ Previously	Allergies/Sinus ❑ Now ❑ Previously	Heart Problems ❑ Now ❑ Previously
Tingling ❑ Now ❑ Previously	Diabetes ❑ Now ❑ Previously	High Cholesterol ❑ Now ❑ Previously
Constipation ❑ Now ❑ Previously	Numbness ❑ Now ❑ Previously	Lung Problems ❑ Now ❑ Previously
High Blood Pressure ❑ Now ❑ Previously	Digestion Problems ❑ Now ❑ Previously	Cancer ❑ Now ❑ Previously

In what areas of your body have you noticed tension/discomfort: _____

Do any activites aggravate this condition(s): _____

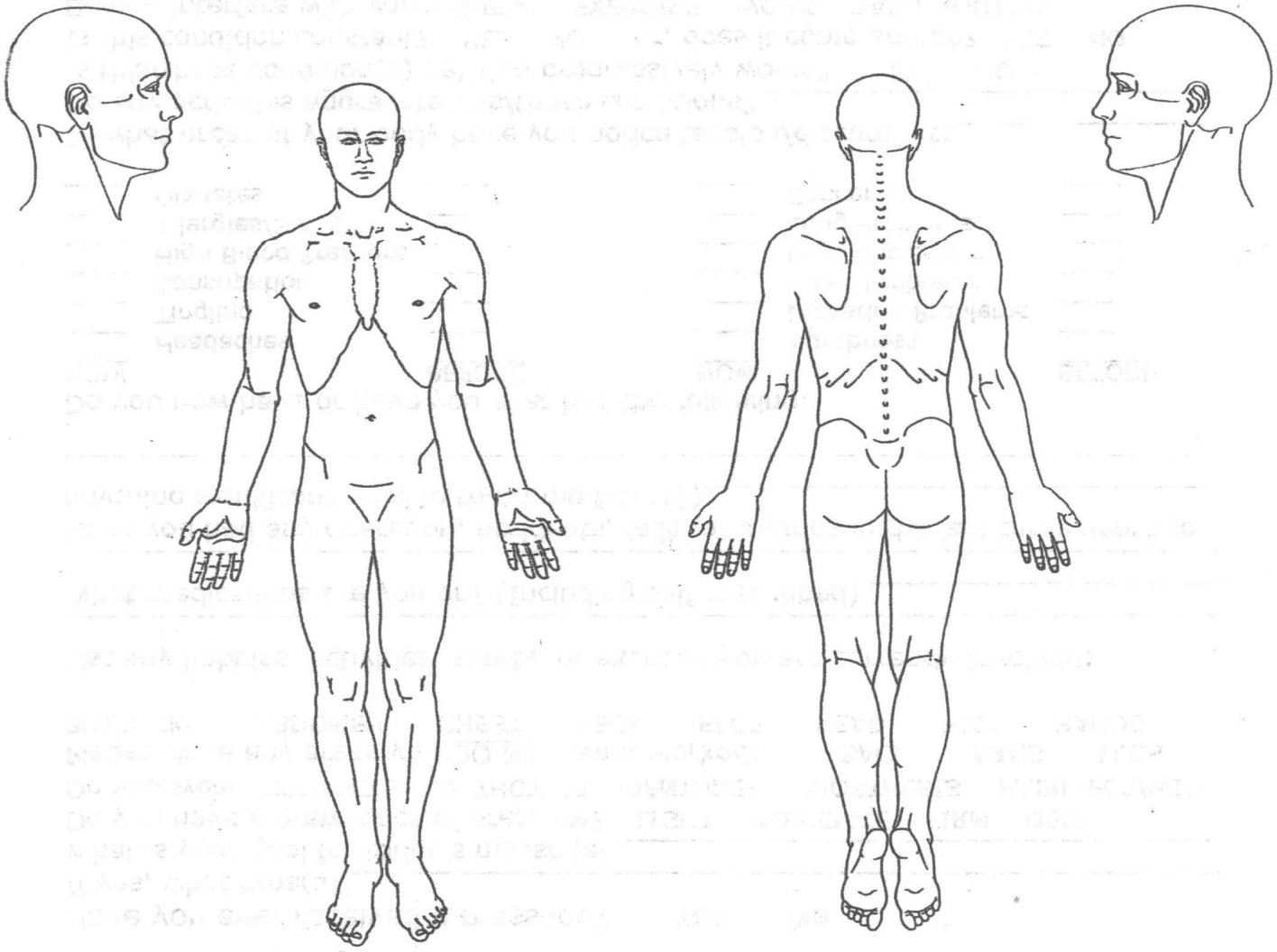
Is this condition(s) getting progressively worse: ❑ Yes ❑ No

Is this condition(s) constant: ❑ Yes ❑ No or does it come and go: ❑ Yes ❑ No

Does it interfere with your: ❑ Sleep ❑ Exercise ❑ Work ❑ Daily Routine ❑ Sports

What is your preferred sleep position: _____

On the diagrams below, please circle any areas that need special attention



I understand this massage is not a replacement for medical care and that no diagnosis will be made. I freely give my permission for the therapy being administered.

Date: _____ Signature: _____

Your appointment time has been set aside exclusively for you!
If you find it neceassry to reschedule, PLEASE notify us at least twenty-four (24) hours in advance. (See following cancellation policy)

THANK YOU

CANCELLATION POLICY

There is no charge for appointments that are cancelled at least twenty-four (24) hours in advance. There is a 50% cancellation fee for appointments that are cancelled with less than twenty-four (24) hours notice, and a 100% cancellation fee for missed appointments.

Please read each clause and acknowledge your agreement by adding your initials in each box.

☐ I hereby acknowledge that all information on this form is accurate to the best of my knowledge

☐ I hereby consent to receiving massage treatment from Lisa A. McCord, LMT

☐ I agree to pay for cancelled or missed appointments as set forth in the Cancellation Policy above

☐ I hereby authorize Lisa A. McCord, LMT, to discuss my condition and treatment with the following

My PHYSICIAN: _____ Phone: _____

My CHIROPRACTOR: _____ Phone: _____

Other: _____ Phone: _____

Date: _____ Signature: _____