TRANQUIL & PURE BODYWORK

Julie Dubravetz, LMT

Name: _____DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Email Address: _____

How did you hear about me? _____

Emergency Contact: _____ Phone: _____

Have you had a professional massage before?

☐ Yes
☐ No

Body/Mind Information:

Please list any medications (including over the counter) that you are taking.

_____ _____
_____ _____
_____ _____

For women, are you currently pregnant? ☐ Yes ☐ No

If yes, how far along? _____

Any risk factors?

_____

Any mental health concerns? ☐ Yes ☐ No

If yes, please describe:

_____

What is your average stress level? ☐ High ☐ Moderate ☐ Low

List stress reduction activities. If none, write none.

_____

_____

Please indicate any of the following that apply to you:

☐ Headaches ☐ Migraines ☐ High blood pressure ☐ Sleep disorder

☐ Low blood pressure ☐ High blood pressure ☐ Sinus problems

☐ Heart attack ☐ Stroke

☐ Diabetes ☐ Neuropathy

☐ Sprains/strains Where? _____

☐ Fibromyalgia ☐ Multiple Sclerosis ☐ Parkinson's

☐ Blood clots ☐ Varicose veins ☐ Lupus

☐ Phlebitis ☐ Hemophilia

☐ Numbness/tingling Where? _____

☐ Arthritis Where? _____

☐ Tendinitis Where? _____

☐ Cancer What kind? _____ When? _____

☐ Allergies _____

☐ Joint Replacement(s). Where? _____

☐ Other:

_____

Are you currently receiving treatment from any other providers? ☐ Yes ☐ No

If yes, please list type of provider and what they are treating:

_____

_____

Where are you currently experiencing discomfort/pain? Please describe in as much detail as you feel would be helpful. If you are not experiencing discomfort or pain, write none or n/a.

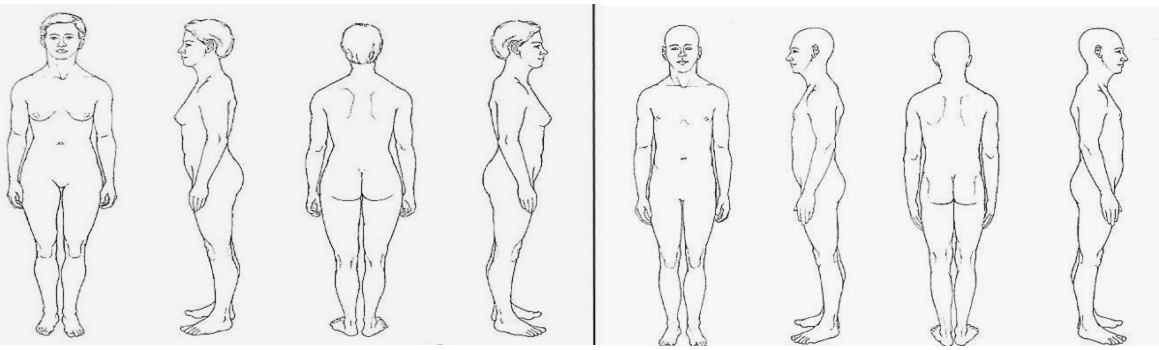
_____

_____

_____

_____

Please circle any areas of concern below:



Previous History:

Surgeries? ☐ Yes ☐ No

If yes, please list type and year received:

_____

_____

Accidents? ☐ Yes ☐ No

If yes, please list year & treatment received:

_____

_____

I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment or perform spinal manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a primary health care provider for that service.

I have stated all known medical conditions and will update the massage therapist of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law.

CANCELLATION POLICY

Please provide a minimum of 24 hours' notice to cancel or change your appointment time. I acknowledge the full rate for services booked will be charged for no-shows. I acknowledge I will be charged full cost of the service for a cancellation with less than 24 hours' notice unless I have become ill.

Signature: _____ Date: _____