

ALPINE THERAPEUTIC MASSAGE
Phoenix Michelle Alexander, L.M.P.#4392
253-838-3336

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CONFIDENTIAL CLIENT INFORMATION FORM

Please Print

Name _____ Phone _____ Birthdate _____
Address _____ City _____ Zip _____ Phone _____
Employer _____ Employer's Address _____ Phone _____
Occupation _____ Chiropractor _____ Phone _____
Physician _____ Phone _____
Emergency Contact _____ Phone _____ Relationship _____
e-mail address : _____ (E-mail will keep you informed of special promotions.)

Health History:

Are you currently taking any medication? _____ If so, what? _____ For what condition? _____
Are you Pregnant? _____ How many weeks? _____ Have you ever had surgery? _____ When _____
For what condition? _____ Date of last Physical Exam _____
Have you had a recent Injury or Illness? _____ What? _____ When? _____ Hospitalized? _____
What results do you want from your massage? _____
Areas needing special attention in your massage _____

Please check the box in front of any conditions that apply to you.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Contagious Condition | <input type="checkbox"/> Cancer | <input type="checkbox"/> Tumors | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Ulcerated Colon | <input type="checkbox"/> Neck/Spinal Injury | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Disc Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Skin Disorders | <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Contacts |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Muscle Tightness | <input type="checkbox"/> Sprain/Strain | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Fever | <input type="checkbox"/> Cold/Flu | <input type="checkbox"/> Sinus Congestion |
| <input type="checkbox"/> MRSA | <input type="checkbox"/> Other _____ | | |

I understand that massage is given for the purpose of stress reduction, relief from muscular tension, spasm, pain, or for increasing circulation. I understand that **Massage Practitioners do not diagnose** illness, disease, or any other physical or mental disorder. They don't prescribe medical treatment, pharmaceuticals, nor perform spinal manipulation. It has been made clear to me that **Massage is not a substitute for medical examination or diagnosis** and that it is recommended that I see a physician for any physical ailment that I might have.

I have stated all my known medical conditions and will keep my Massage Practitioner updated on my health.
I consent to massage therapy. Initials _____

Financial Policy:

Payment is due at the time of each visit, unless other specific arrangements are made. I understand and acknowledge that: my health insurance policy is an arrangement between the health plan and myself, I am responsible for all bills incurred during treatment, and that ALL insurance payments are due within 60 days of treatment.

Cancellation Policy: Your appointment is reserved for you. Please give 24 hours notice if you are unable to keep your appointment. If cancelled less than 24 hours in advance will be charged \$35.00 for late cancellation. **Reservation is guaranteed with a credit card. Insurance clients will be billed personally for missed appointments.**

No Show Policy: If you do not call and cancel your appointment with 24 hours notice, you may be charged the full amount for your appt. If prepaid with Gift Certificate, Groupon, Monthly Club etc., funds will apply to the missed appointment.

I have read and understand the financial and cancellation policy. Initials _____

Privacy Policy

I have been given a copy of the Privacy Policy. I don't have any questions about it. Initials _____
(Or: Initials _____ I have questions and would like the Privacy Officer to contact me.)

Signature _____ Date _____

I Reserve The Right To Refuse Anyone Service