Confidential Health Form

Name_____ Contact me by:

Preferred Name and/or Pronoun ___Email ___Phone

_____ ___US Mail ___No Preference

Address_____

City/State/Zip_____ Referred by_____

Email_____

Phone_____ Have you ever had a massage before?

Date of Birth_____/_____/_____ (Circle) Yes No

Occupation_____

Areas of your body that you hold tension or stress (Circle)

Head/face Shoulders Neck Upper back Mid back Low back Abdomen Hips Chest Arms Hands Front of legs Back of legs Feet Other/specific spot_____

Are you currently being treated for a medical condition? (Circle)

Pain High blood pressure Gastrointestinal Fibromyalgia Skin conditions Arthritis Cancer/Tumors Heart Liver Thyroid Urinary Respiratory Areas of numbness TMJ Diabetes 1-2 Infection Other Condition(s)_____

What activities/therapies have you found helpful for your lifestyle? (Circle)

Physical Therapy Chiropractic Nutritionist Yoga Running Walking Weight Training Massage Meditation Acupuncture Swimming Sports Pilates Dance Other_____

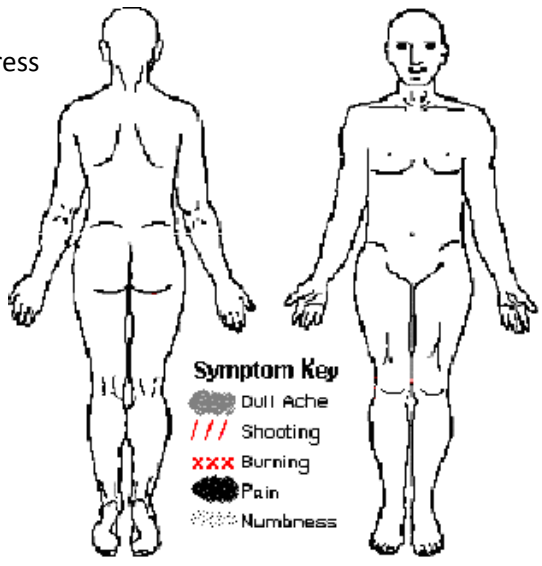
Medications you are currently using_____

What results do you want from your treatments?

General relaxation Relief from pain More range-of-motion Decrease stress

Using the Symptom Key, please mark the picture

where you have pain or other symptoms: → → →



Joint Ventures℠
Physical Therapy and Fitness

MASSAGE CONSENT TO TREAT

I hereby request and consent to the performance of massage treatments and other procedures within the scope of the practice of massage on me (or on the patient named below, for whom I am legally responsible) by the massage therapist named below and/or other licensed massage therapists who now, or in the future, treat me while employed by, working or associated with, or serving as back-up for the massage therapist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, Swedish massage, deep tissue massage, trigger point therapy, Myofascial release techniques, Thai massage, stress reduction techniques, injury rehabilitation techniques, pre-natal and post-natal techniques, energetic work, body awareness work, postural techniques, hot stone massage, reflexology, sports massage techniques, facilitated stretching techniques, and medical massage.

I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed. I understand the clinical and administrative staff may review my patient records, but all my records will be kept confidential and will not be released without my written consent.

I, the undersigned, hereby expressly and affirmatively state that I wish to participate in massage. I realize that my participation in this activity involves risks of injury including but not limited to: cardiovascular and orthopedic type injuries, serious disabling injuries, and even the possibility of death. I also recognize that there are many other risks of injury that may arise due to my participation in this activity, and that it is not possible to specifically list each and every individual injury risk. However, knowing the material risks and appreciating, understanding, and anticipating that other injuries and even death are a possibility, I hereby expressly assume all of the delineated risks which could occur by reason of my participation. I have had an opportunity to ask questions. Any questions I have asked have been answered to my complete satisfaction. I subjectively understand the risks of my participation in this activity, and I voluntarily choose to participate, assuming all risks due to my participation.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE (Or Patient Representative – indicate relationship if signing for patient) **(Date)**

X

PRACTITIONER SIGNATURE **(Date)**

X

Appointment Cancellation Policy
We require 24 hours' notice for any cancellations, otherwise you will be responsible for paying your usual treatment fee. Appointments may be canceled by calling (617) 536-1161.

Appointment No-Show Policy
When you set an appointment, we sets aside time in the schedule just for you, so we can be certain to provide you the care you need. We value your time and know you value ours. If you cannot come to your appointment and haven't canceled, you will be charged a regular appointment fee. If you are using a promotional gift certificate, such as Groupon, we will redeem your gift certificate as being used.

Please initial below to confirm that you agree to our policies and agree to make payment for missed appointments.
Please Initial here:_____