Republic of Wellness Massage Therapies

Name: ______________________________ Date of Birth: ______________________

Address: ______________________________ City, State, and Zip: ______________________

Cell Phone: ______________ Home Phone: ______________ Occupation: ______________________

Email Address: ____

(Please provide email address – your information won't be shared, you won't be spammed from us. We respect your privacy)

Main Reason for your appointment today: 0 Relaxation and/or 0 Pain Relief

How did you hear about the Republic? Please be as specific as you can: ______________________________

All of the information provided below will remain strictly confidential. For certain medical conditions or symptoms, massage may be contraindicated. In such cases a referral from your primary care provider may be required prior to a session.

Would you like to receive a birthday discount? 0 Yes 0 No *$30 off any treatment during the month of your birthday- for current clients only)

Have you ever received a professional massage? 0 Yes 0 No How recently? ______________________________

List any likes or dislikes: ____

If you answer "yes" to any of the following questions, please explain as clearly as possible in the lines provided below.

0 Yes 0 No Do you frequently suffer from stress? Stress level: Lowest - 1 2 3 4 5 6 7 8 9 10 - Highest
0 Yes 0 No Do you have diabetes?
0 Yes 0 No Are you pregnant?
0 Yes 0 No Do you suffer from arthritis?
0 Yes 0 No Do you have osteoporosis?
0 Yes 0 No Do you have high blood pressure?
0 Yes 0 No Do you suffer from epilepsy or seizures?
0 Yes 0 No Do you have varicose veins?
0 Yes 0 No Do you have any contagious disease?
0 Yes 0 No Have you ever been bruised by a massage?
0 Yes 0 No Have you had any broken bones in the last 2 years?
0 Yes 0 No Have you had any recent surgeries?
0 Yes 0 No Have you been in an accident or suffered any injuries in the last 2 years?
0 Yes 0 No Do you have any cardiac or circulatory problems?
0 Yes 0 No Do you have any other medical condition or are you taking any medications?
0 Yes 0 No Do you have any known allergies?
0 Yes 0 No Are you very sensitive to touch or pressure in any area?
0 Yes 0 No Do you have TMJ pain syndrome?
0 Yes 0 No Do you exercise regularly?
0 Yes 0 No Do you experience frequent headaches?
0 Yes 0 No Do you have numbness or stabbing pains anywhere?
0 Yes 0 No Do you have any tension or soreness in a specific area?

Please explain: ____

Disclaimer

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment I am aware of. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

Cancellation Policy and Payment for Services Rendered

I understand that it is my responsibility to pay one half of the fee for any session that I cancel with less than six hours notice. If I do not show up at all, I am responsible for the full fee of any booked session. I understand and agree that I am personally responsible for payment of all services rendered to me which are due and payable immediately upon completion of service.

Client Signature: ______________________________ Date______________________