Therapeutic Massage & Bodywork, LLC

Staff Verify I.D. Initials_____ Verify Address Match Yes No
State:_____ ID#_____

Welcome!

Client Information

First Name:_____ MI:_____ Last Name:_____

Address:_____ City:_____ State:____ Zip:_____

Home Phone: (_____)_____ Mobile/ Text #: **(_____)**_____

Email: _____ Date of Birth: _____Gender: ❑ Male ❑ Female

Insurance Company: _____*Relationship to Insured* _____

*Member/Claim #*_____ ❑ *Married* ❑ *Single* ❑ *Divorced* ❑_____

Occupation: _____Patient's Employer/School: _____

Who may we thank for referring you? _____

Emergency Contact

Name: _____ Relationship: _____

Phone #1: **(____)**_____ Phone #2: (_____)_____

Payment Agreement/Professional Conduct

I understand that I am financially responsible for all charges on my account. I agree to pay interest on any unpaid balance regarding this account of 2% per month (20% per annum). If it becomes necessary to refer the account to a collections agency, I agree to pay a collection fee of 35% of the outstanding balance owing. Further, I agree to pay for any and all attorney's fees and court costs incurred. I authorize the release of any medical and or other information necessary for obtaining payment for services.

Payment must be made at the time of service. Therapeutic Massage Rates are as follows:

Time of Service:	**Advanced Time of Svc:**	**Prescribed:**	**Chiropractic**
1-Hour $45	1-Hour $60	Evaluation $35	Initial Office Visit $30
90-Min $65	90-Min $80	97140 (15min) $32.20	Office Visit $30
2-Hour $90	2-Hour $105	97124 (15min) $25.87	Co-pay $_____

Cancellation Policy: Any appointment not able to be kept must be canceled with 24-hours notice. By signing below you agree that we may keep your credit/ debit card on file in accordance with PCI Compliance laws to be processed for these such circumstances: Any appointment not cancelled accordingly will be charged to you at the customary hourly rate. Two or more "no-shows" or "late-cancellations" will require pre-payment for all future appointments. Please be courteous, the time we have scheduled is valuable. **Initial: ____**

Privacy Policy: TMB will not release any of your personal or health information without your express written consent, except as needed for billing and collection purposes. TMB will never sell or otherwise use your personal or health information for outside marketing purposes. We do however reserve the right to use your personal information for our own internal marketing purposes.

Informed Consent: I have had the opportunity to discuss with your practitioner the purpose and benefits of the treatments outlined below. Alternatives to treatment have been reviewed. **Initial: ____Therapeutic Massag**e; ____Cupping Massage; ____Gua Sha; ____Energy Work; ____Stretches/Exercises; _____**Chiropractic Care**

I understand that **any remarks or actions that may be construed as illicit or sexually suggestive** will result in **immediate** termination of the therapeutic massage session, and I will be held liable for payment of the full scheduled amount.

_____ _____

Patient/Guarantor Signature **Date**

Therapeutic Massage & Bodywork, LLC

Client Name: _____Date:_____

Current Condition

What is the purpose for your visit today? _____

Does anything hurt? Yes No Where? _____ How Long?_____

Is your condition getting worse? Yes No Unknown Is it getting better? Yes No

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting

❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other_____

How often do you have this type of pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ❑Work ❑Sleep ❑Daily Routine ❑Recreation ❑Other _____

Activities that are difficult to perform ❑Sitting ❑Standing ❑Walking ❑Bending ❑Lying Down

Have you had any falls or accidents? ❑No ❑Yes Date:_____ Type: ❑Auto ❑Work ❑Other

Have you had a professional massage before? ❑No ❑Yes Last Massage? _____

Have you ever had chiropractic care or Physical Therapy? ❑No ❑Yes-When?_____

Have you ever had a chiropractic adjustment immediately following a massage? No Yes

How many hours/day do you spend: Sitting_____ Standing _____ Light Labor _____ Heavy Labor_____

How often do you exercise? None Moderate Daily Activity: (swim, run, etc.) _____

Health History: **Circle all that apply.** **Write the name of any other conditions.**

HEAD:	Headaches—mild—moderate—severe	NONE	Other:_____
SPINE:	Congenital disorders—Scoliosis—Herniated disc—Sciatica	NONE	Other:_____
NECK:	Swollen glands—Thyroid problems—Herniated disc	NONE	Other:_____
ARM/HAND:	Pain in arm— Hand numbness—Shoulder pain—Tingling—Wrist pain	NONE	Other:_____
LEG/FOOT:	Pain in legs—Knee pain—Hip pain—Ankle pain—Tingling— Foot pain—Numbness in foot	NONE	Other:_____
NEURO:	Convulsions—Seizures—Fainting—Stroke	NONE	Other:_____
PYSCH:	Depression—Anxiety—Stress/Excess worry—Drug/Alcohol issues—A.D.D.	NONE	Other:_____
EYES:	Visual problem—Blurry vision—Red eyes	NONE	Other:_____
NOSE:	Nasal allergies—Nose bleeds—Sinus problems	NONE	Other:_____
THROAT:	Swallowing difficulty—Frequent sore throats—Speech problems	NONE	Other:_____
MOUTH:	Dental problems—Tongue problems—Canker sores	NONE	Other:_____
CHEST:	Asthma—Shortness of breath—Cough	NONE	Other:_____
HEART:	Chest pain— Murmurs—Palpitations—Valve problems—Angina	NONE	Other:_____
INTESTINAL:	Colitis—Ulcer gastritis—Esophagus problems—Polyps—Constipation	NONE	Other:_____
URINARY:	Urinary problems—Urinary frequency—Burning—Kidney stones	NONE	Other:_____
GENITAL:	Infection—Warts—Impotence—Sexual difficulty	NONE	Other:_____
SYSTEMIC:	Weight loss—Fever—Sleeping diff—Loss of energy—Arthritis	NONE	Other:_____

Medications: Name_____ Condition_____

Name_____ Condition_____

Surgery:_____ Date:_____

Surgery:_____ Date:_____

801-899-3904 ▪ 140 S. Main Street #3 Pleasant Grove, UT