

Soulstice, Ltd.
"Inspiring Wellness Through Massage"
Confidential Client Information and Health History

Today's Date: _____ Date of Birth: _____ Gender: M F

Full Name: _____ Nickname: _____

Address: _____
Street Apt # City/State Zip Code

Home Phone: _____ Cell Phone: _____ Work/Other Phone: _____

Preferred method of PHONE contact: Home Cell Work **OR** E-MAIL

E-mail address: _____ Occupation/Employer: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

What physical activities/exercise programs are you involved in? How often? What kind? _____

Are you a recent surgical patient? **YES NO** (If yes, please complete the following)

What was the **date** of your surgery? _____

What **procedure(s)** did you undergo? _____

Who was your **surgeon**? _____ Are you wearing a compression garment? _____

Other pertinent medical history (i.e. medical conditions, past surgeries, injuries, accidents, chronic pain):

Are you currently taking any medications? (including herbs, vitamins and over-the-counter meds)? **YES NO**
If yes, please describe (temporary or regular) _____

What is your main work activity? **PHONE SITTING COMPUTER DRIVING MANUAL OTHER**

Have you ever had massage? **YES NO** For what reason? _____
How long ago? _____ How was your experience? _____

Are you currently receiving any other treatment modalities (i.e. acupuncture, physical therapy, chiropractic, naturopathic, etc.)? _____

Do you have any known allergies? _____

Please check any and all that apply to your present health condition

- | | | |
|--|---|--|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Feelings of Anxiety |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> High Stress |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Skin Condition/Rash | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Muscle/Joint Pain |
| <input type="checkbox"/> TMJ/Jaw Pain/Grinding | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Sprains/Strains |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Area of Inflammation | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Cancer/Tumors |
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Infectious Disease |
| <input type="checkbox"/> Shooting Pains | <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Depression | |

- I hereby authorize the release of my medical information necessary to provide effective care and communication between Soulstice and my referring physician, healthcare providers, and/or insurance companies to process my insurance claim (if applicable). This may include intake forms, chart notes, correspondence, billing statements, any other information either written or verbal.
- I am responsible for all charges for services rendered. If my insurance company denies benefits or makes partial payments, if applicable, I am responsible for any balance due.
- I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately. I have discussed/stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.
- Your massage therapist cannot make any diagnosis. Any suggestions made during your visit are recommendations or observations. You will be referred to your surgeon/medical practitioner for any specific questions regarding your health and/or surgery.
- Scheduling & Cancellation Policies: Soulstice enforces a 24-hour cancellation policy. Failure to cancel within 24 hours or failure to appear for a scheduled appointment will be subject to forfeiture and/or will be charged accordingly. I understand that insurance companies do not pay for cancellation fees.
- Insufficient funds: Client will be charged a \$20 fee in addition to the full payment for services rendered for any returned checks.

Insurance Information: (do NOT complete if you are a "self-pay" client)

Was injury a result of an accident? _____ If yes, was it: JOB AUTO Other: _____
Date of injury or onset: _____ Social Security Number: _____
Insurance Company Name: _____
Billing Address: _____
Phone Number: _____ Adj. Phone/Ext: _____
Adjuster/Claims Rep: _____
Insured/Responsible Party Name: _____
Address: _____
Phone Number: _____ Social Security Number: _____
Claim/Case Number: _____
Attorney Name (if any): _____ Phone Number: _____
Address: _____

I have read and I understand the above policies.

Client Signature: _____ **Print Name:** _____ **Date:** _____

Consent for Minors: By my signature below, I hereby authorize massage therapy treatment to my child or dependent as deemed necessary.

Signature of Parent or Guardian: _____ Date: _____

Reviewed by Massage Therapist: _____ Copy of policies given to patient: Y N Date: _____

For office use: Information entered into client database on _____ by _____