



Personal Information

Today's Date

First and Last Name

Birthday

Phone

Email

Address

City State Zip / Postal Code

Occupation

Employer

Primary Physician

Emergency Contact

Relationship

Emergency Contact Number

Medical Information

Are you taking any medications? Yes No If yes, please list name and use.

Are you currently pregnant? Yes No If yes, how far? Any high-risk factors?

Do you suffer from chronic pain? Yes No If yes, please explain

What makes it better?

What makes it worse?

Have you had any orthopedic injuries? Yes No If yes, please list:



Please indicate any of the following that apply to you:

- Cancer Headaches/Migraines Arthritis Diabetes
- Joint Replacement(s) High/Low Blood Pressure Neuropathy
- Fibromyalgia Stroke Heart Attack Kidney Dysfunction
- Blood Clots Numbness Sprains or Strains

Explain any conditions you may have marked above: _____

Massage Information

Have you had a professional massage before? Yes No

What pressure do you prefer? Light Medium Deep

Do you have any allergies or sensitivities? Yes No

Are there any areas you do NOT want massaged?

Feet Face Abdomen Chest Other _____

What are your goals for this treatment session? _____

Select any areas you'd like me to focus on...

- Shoulder Neck Head Face Hands Upper Back
- Lower Back Legs Feet Other _____

Policies

We are 100% committed to your satisfaction.

Please read and sign each policy to ensure you have a GREAT experience with us.

Cancellations/Rescheduling:

- If I am not able to make a scheduled appointment, I agree to cancel or reschedule the appointment at least 48 hours in advance. I agree to pay \$40 or 50% of the full session rate (whichever is greater) if I give less than 48 hours' notice. _____(initials)



- I agree to pay the full session rate if I give 12 hours' notice or less, or if I miss an appointment without giving notice. _____(initials)
- If within 48 hours of my appointment, I develop a contagious illness or have a sudden, unplanned health or personal emergency rendering me unable to make my appointment, I will inform West Broward Therapeutic Massage LLC right away, and if you are unable to fill my vacancy, I will pay the cancellation fee, or session fee (if less than 12 hours' notice). *If an exception is granted it is only on case-by-case basis and at the discretion of West Broward Therapeutic Massage LLC* _____(initials)
- I understand that I am still responsible for my appointment until I hear back from a staff member confirming they received my email, text or phone call requesting cancellation/rescheduling. _____(initials)
- I understand that I must keep a current active credit card on file with West Broward Therapeutic Massage in order to remain a current patient and on the schedule. _____(initials)

Arriving on Time/Session Length:

- I understand I must arrive 10-15 minutes early for my appointment in order to get the full session time I have scheduled. If I arrive at the appointment time, or late, I understand the therapist can only give me whatever time remains of my appointment, and that I will pay for the full length of the session I booked. _____(initials)
- I understand that for me to receive the best massage therapy possible, I know that I have to communicate ANYTHING and everything, including my needs, preferences, requests, or feedback at any time before, during or after my massage. I take it upon myself to communicate right away if there is anything distracting me or if I feel unwell or uncomfortable at any time during the session, so that adjustments can be made. I understand that my therapist wants my HONEST feedback – positive or negative – and doesn't take offense to it. _____(initials)

I have read, understand, and agree to the above policies and information.

Signature: _____

Date: _____