

NORTH AUSTIN MASSAGE THERAPY
Client Information Form

Name _____ Today's Date _____
Address _____ City _____ State _____ Zip _____
Email Address: _____ Birth Date: _____ Weight _____ Height _____
Tel: (Hm) _____ (Wk) _____ (Cell) _____
Occupation _____ Employer _____
Referral by? Friend _____ Doctor _____ Yel. Pgs. ___ Sign ___ Web ___ Other _____
List ALL Medications and/or supplements:

Physician's Name: _____ Chiropractor's Name: _____
Chiropractic Care (check one): Current ___ Previous ___ Never ___ Reason for care: _____

CONTACT LENSES? YES / NO (circle one)
DENTURES? YES / NO (circle one)
RIGHT-HANDED or LEFT-HANDED? (circle one)
PREGNANT? YES / NO (If yes # of weeks _____ & due date _____)
Describe previous MASSAGE experience: _____
Describe Current EXERCISE program: _____
Primary REASON for appointment: _____
Additional COMPLAINTS: _____

Please check if any of these conditions apply and briefly DESCRIBE & give DATES:
Diabetes () Insulin Dependent () Injections () Medications () _____
Spinal Injury () _____
Surgery () _____
Sciatic Problems () _____
Pinched Nerve () _____
Blood Clots or History of Blood Clots () _____
Circulatory Problems (Varicose Veins, Phlebitis, Hardening of Arteries, Aneurysm) () _____
Tumor () _____
Communicable Disease () _____
Breathing Problems () _____
Pregnancies? Dates () _____
Chronic Pain () _____
Migraines/Headaches () _____
Cancer () _____ Chemo or Radiation () _____
Allergies, Skin Problems or sensitivity to oils/lotions etc. () _____

Broken Bones () _____
Car Accidents or Major Injuries () _____

Scars () _____
List other medical conditions we should be aware of before administering Deep Muscle Therapy:

IF ACCIDENT, please give a brief description of what happened. _____

Claim #: _____ PIP _____ Soc. Sec. _____
Insurance Company _____ Tel. #: _____ Ext: _____
Address _____ Fax #: _____
Adjustor's Name _____ Date of Injury: _____

PLEASE READ AND SIGN BELOW:

I understand that the muscle therapy given at North Austin Massage Therapy (NAMT) is for the purpose of relief from muscular tension, stress, muscle damage, and for improving circulation and general health. I understand that muscle therapists do not diagnose illness, disease, or any physical or mental disorder. As such, the muscle therapist does not prescribe medical treatments or pharmaceuticals, nor do they perform any spinal manipulations. It has been made very clear to me that this muscle therapy is not a substitute for medical examinations, and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because a muscle therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the muscle therapist updated on my physical health changes. Draping will be provided during the session, and breast massage will not be done without previous discussion and permission of the client. If the client or therapist feels uncomfortable at any time, they may terminate the therapy session.

NAMT requires 24-hour notice for cancellations. I understand that there will be a \$50.00 fee for the first time, and FULL PRICE for subsequent times of no-show or last minute cancellations for any future appointments. I am aware that I can call 24 hours, and email changes if I am unable to make an appointment. I am also aware that there is a \$50.00 charge on all returned checks.

In accordance with the Health Information Privacy Act, I realize that I must give my permission in writing for release of medical records. By signing below, I am stating that I read the above information.

I give my permission for North Austin Massage Therapy to contact me for appointment reminders using voicemail messages, emails, faxes, postcards or letters.

By initialing here, I give my permission for NAMT to contact my doctor if needed _____.

The Therapist may use one or more of the following techniques today and on future appointments:

Crossfiber Corrective Muscle Therapy	Pfirmer Deep Muscle Therapy
Sports Massage	CranioSacral Therapy
MyoFascial Release Therapy	Swedish Deep Muscle Therapy
Strain/Counterstrain Exercises	Manual Lymphatic Drainage
Range of Motion Exercises	Positional Release

Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Witness Signature: _____ Date: _____