

Accent On Massage

For health and well-being

Ute Boehm, CMT

WI License # 516-048

431 E. Clairemont Ave.

Eau Claire, WI 54701

Phone: 715-832-2223

Fax: 715-832-7416

| | | | |
|--|---|------------------------|----------------|
| NAME | | PHONE | |
| ADDRESS | | CITY | STATE ZIP |
| AGE | <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | REFERRED BY: | |
| Emergency Contact | | Phone | Relationship |
| Occupation | | List daily activities: | |
| Are you currently taking medication? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| If yes, please list and explain | | | |
| Have you received Massage Therapy before? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| What are your main concerns and goals for your treatment today? | | | |

Do You Have a History Of?

- | | |
|--|---|
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Arthritis/Bursitis/Gout |
| <input type="checkbox"/> Neck Pain/Whiplash | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Back Pain – Mid/Low/Disc problems | <input type="checkbox"/> Heart Attack/Stroke |
| <input type="checkbox"/> Dizziness/Seizures | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Are you Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Stress/Nervous Tension | <input type="checkbox"/> Wear contact lenses or other prosthesis |
| <input type="checkbox"/> Other emotional or psychological conditions | <input type="checkbox"/> Allergies to perfumes or oils |
| <input type="checkbox"/> Sprains/Broken Bones | <input type="checkbox"/> Have a contagious Disease |
| <input type="checkbox"/> Joint aches/decreased range of motion | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Comments: _____ |
| <input type="checkbox"/> Been in an accident or suffered an injury in the past 2 years | _____ |

Do You Have Any of the Following Today?

- | | | |
|--|--|--|
| <input type="checkbox"/> Cold/Flu | <input type="checkbox"/> Sunburn | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Open cuts, bruises, burns | <input type="checkbox"/> Inflammation | <input type="checkbox"/> Irritated skin rash |
| <input type="checkbox"/> Severe pain | <input type="checkbox"/> Other concerns: _____ | |

PLEASE READ THE FOLLOWING AND SIGN BELOW:

- ♦ I understand that the massage received is not a replacement for any medical care, and that a diagnosis cannot and will not be made.
- ♦ Massage/bodywork should not be performed under certain medical conditions, I affirm I have provided all my known medical information.
- ♦ I agree to inform the therapist on any new injuries and keep the therapist updated as to any changes of my medical status.
- ♦ I understand that any illicit or sexually suggestive remarks or advances made by myself will result in IMMEDIATE TERMINATION of the session, and I will be LIABLE FOR PAYMENT of the scheduled appointment.

Signature: _____

Date: _____

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I _____ (client) understand that massage therapy provided by my Therapist is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes of massage therapy are specified below:

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my primary health care provider for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and will keep the massage therapist updated on any changes.

Client Signature _____ Date _____

☞ **We would appreciate all appointments to be kept in a timely manner** ☞

We reserve the right to charge you for any missed appointments.

Please make any necessary cancellations within a 12 hour time period

**CONFIDENTIAL
PROTECTED HEALTH INFORMATION
AUTHORIZED PERSONNEL ONLY**