elemental
massage therapy & spa

Please fill out all boxes and hand this form to your massage therapist or the front desk.

PATIENT INFORMATION		
First Name	Last Name	Email Address
Date of Birth	Gender	

CONTACT INFORMATION		
Home Phone	Cell Phone	Work Phone
Address		City
State	Country	Zip Code

EMERGENCY CONTACT		
Name	Phone	Relationship to Patient

GENERAL INFORMATION		
Occupation	Source of Referral	Current Treatments Elsewhere
Primary Complaint		
History of Massage Therapy, PT, Chiro, etc.		
General Health		

FEMALE HEALTH		
Currently Pregnant? ☐ Yes ☐ No	Due Date	Weeks Pregnant

ONCOLOGY	
Cancer Type	Lymph Nodes Removed

ENDOCRINE
Diabetes? ☐ Yes ☐ No

WELL BEING		
How often do you exercise?	Flexibility?	Range of Motion?

ADDITIONAL INFORMATION		
Medications	Surgeries	Injuries
Other		

Please place a check mark in all boxes that apply to you.

AREA OF COMPLAINT

☐ Left Side of Neck	☐ Chest	☐ Left Hand	☐ Left Foot
☐ Right Side of Neck	☐ Abdomen	☐ Right Hand	☐ Right Foot
☐ Left Side of Upper Back	☐ Left Shoulder	☐ Left Hip	☐ Left Leg
☐ Right Side of Upper Back	☐ Right Shoulder	☐ Right Hip	☐ Right leg
☐ Left Side of Mid Back	☐ Left Elbow	☐ Left Knee	☐ Left Arm
☐ Right Side of Mid Back	☐ Right Elbow	☐ Right Knee	☐ Right Arm
☐ Left Side of Low Back	☐ Left Wrist	☐ Left Ankle	☐ Other:_____
☐ Right Side of Low Back	☐ Right Wrist	☐ Right Ankle	

HEADACHES

☐ Chronic Daily Headache	☐ Headaches	☐ Rebound	☐ Tension
☐ Cluster	☐ Migraines	☐ Sinus	☐ Other:_____

BLOOD

☐ Anemia	☐ Hepatitis	☐ HIV/AIDS	☐ Thrombosis/Embolism
☐ Bleeding Disorder	☐ High Cholesterol	☐ Hypercoagubility	☐ Other:_____
☐ Haemophilia	☐ HIV	☐ Polycythemia	

CARDIOVASCULAR

☐ Acute Coronory Syndrome	☐ Cardiovascular Conditions	☐ Heart Attack	☐ Pericarditis
☐ Aneurysm	☐ Chronic Ischemic Disease	☐ Heart Disease	☐ Phlebitis
☐ Angina	☐ Chronic Venous Insuffic.	☐ High Blood Pressure	☐ Raynaud Disease
☐ Atherosclerosis	☐ Cold Feet	☐ Hyperlipidemia	☐ Rheumatic Heart Disease
☐ Blood Clots	☐ Cold Hands	☐ Low Blood Pressure	☐ Valve Disorders
☐ Blood Pressure	☐ Congenital Heart Defect	☐ Lymphedema	☐ Varicose Veins
☐ Cardiac Arrhythmia	☐ Congestive Heart Failure	☐ Myocardial Infarction	☐ Other:_____
☐ Cardiovascular Accident	☐ Coronary Artery Disease	☐ Pacemaker	

ENDOCRINE

☐ Acute Pancreatitis	☐ Hyperthyroidism	☐ Pituitary & Growth Disorder	☐ Other:_____
☐ Diabetes	☐ Hypothyroidism	☐ Prostate Condition	

FAMILY HISTORY

☐ Arthritis	☐ Cardiovascular	☐ Respiratory	☐ Other:_____

GASTROINTESTINAL

☐ Celiac Disease	☐ Digestive Conditions	☐ Fecal Impaction	☐ Stomach Disorder
☐ Constipation	☐ Diverticulitis	☐ Intestinal Polyps	☐ Ulcerative Colitis
☐ Chrohn's Disease	☐ Eating Disorder	☐ Irritable Bowel Syndrome	☐ Other:_____
☐ Diarrhea	☐ Esophageal Disorder	☐ Poor Appetite	

HEARING

☐ Conductive Hearing Loss	☐ Hearing Loss	☐ Motion Sickness	☐ Vertigo
☐ Ear Problems	☐ Meinere Disease	☐ Tinnitus	☐ Other:_____

IMMUNE

- ☐ Allergies
- ☐ Anaphylaxis
- ☐ Cancer
- ☐ Hodgkin Lymphoma
- ☐ Infectious Mononucleosis
- ☐ Leukemia
- ☐ Lupus
- ☐ Non-Hodgkin Lymphoma
- ☐ Rheumatoid Arthritis
- ☐ Other:_____

KIDNEY

- ☐ Bladder Disorder
- ☐ Chronic Kidney Disease
- ☐ Other:_____
- ☐ Congenital Kidney Disease
- ☐ Electrolyte Imbalance
- ☐ Kidney Stones
- ☐ Renal Cysts
- ☐ Urinary Incontinence
- ☐ Urinary Tract Infection

MUSCULOSKELETAL

- ☐ Amyotropic Lateral Sclerosis
- ☐ Ankylosing Spondylitis
- ☐ Other:_____
- ☐ Compartment Syndrome
- ☐ Dislocation
- ☐ Muscular Dystrophy
- ☐ Myasthenia Graavis
- ☐ Psoratic Arthritis
- ☐ Scleroderma

NEUROLOGICAL

- ☐ Brain Disorder
- ☐ Brain Injury
- ☐ Burning
- ☐ Cerebral Palsy
- ☐ Stroke
- ☐ Cerebral Vascular Accident
- ☐ Chronic Pain Disorder
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Herniated Disc
- ☐ Huntington Disease
- ☐ Loss of Sensation
- ☐ Multiple Sclerosis
- ☐ Numbness
- ☐ Parkinson's
- ☐ Sciatic Pain
- ☐ Seizure Disorder
- ☐ Shingles
- ☐ Stabbing
- ☐ Stroke
- ☐ Tingling
- ☐ Transient Ischemic Attacks
- ☐ Vertebral/Spinal Cord Injury
- ☐ Other:_____

REPRODUCTIVE

- ☐ Breast Disorder
- ☐ Ectopic Pregnancy
- ☐ Endometriosis
- ☐ Gynaecological Conditions
- ☐ Menopause
- ☐ Menstrual Cycle Disorder
- ☐ Ovarian Cysts/Tumors
- ☐ Pelvic Inlammatory Disease
- ☐ Pregnancy
- ☐ Premenstrual Syndrome
- ☐ Uterine Disorder
- ☐ Other:_____

RESPIRATORY

- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ COPD
- ☐ Cystic Fibrosis
- ☐ Emphysema
- ☐ Infectious Conditions
- ☐ Respiratory Conditions
- ☐ Respiratory Tract Infection
- ☐ Shortness of Breath
- ☐ Tuberculosis
- ☐ Other:_____

SKIN

- ☐ Acne
- ☐ Allergic Dermatosis
- ☐ Athlete's Foot
- ☐ Bruise Easily
- ☐ Other:_____
- ☐ Chemical Burn
- ☐ Herpes
- ☐ Hypersensitive Reactions
- ☐ Infectious Skin Conditions
- ☐ Melanoma
- ☐ Carcinoma
- ☐ Pigmentary Disorder
- ☐ Plantar's Wart
- ☐ Psoriasis
- ☐ Rash
- ☐ Rosacea
- ☐ UV Burn

MISCELLANEOUS

- ☐ Insomnia
- ☐ Mental Illness
- ☐ Surgical Pins or Wires
- ☐ Vision Loss
- ☐ Vision Problems
- ☐ Other:_____

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PLEASE READ & INITIAL EACH LINE, AND SIGN BELOW.

INSURANCE BILLING POLICIES

_____ I agree to the release of information to be used for medical and/or insurance billing purposes.

_____ I will not hold Elemental Massage Therapy & Spa responsible to know my health insurance benefits if I have not called for them myself.

_____ It is my responsibility to track my massage in relation to my plan benefits so my benefits are not maxed.

_____ I am aware that I am fully responsible for all health care bills for services rendered and that payment is not contingent on any settlement, judgement or insurance payment. An unpaid balance is due 30 days from the invoice/statement date. A 1% interest or minimum of $1.00 per month with be charges until the balance due is paid. Rebilling fees may be added. Each returned check will be charged $25.00 plus bank fees. Additional court, attorney or collection agency fees may be charged, up to 50% if applicable.

OFFICE POLICIES

_____ I acknowledge that all information provided is complete and accurate. I will notify Elemental Massage Therapy & Spa of any changes to the information presented on this form. Any changes in my physical condition will be told to my treating LMP prior to treatment.

_____ I understand my massage therapist/esthetician does not diagnose illness or disease, or prescribe any treatments.

_____ I will not hold Elemental Massage Therapy & Spa nor any of its employees responsible for any injury sustained during or after my service.

_____ I will notify Elemental Massage Therapy & Spa if any injury does occur.

_____ I have been given or offered privacy/HIPPAA information (It is taped to the clipboard.)

_____ I agree to cancel appointments no more than 24 hours in advance.

_____ **I understand that missed or cancelled appointments without 24 hour notice will be charged a fee equal to the full cash price of the missed session**.

⇨ Client Signature: _____ Date: ____ /____ /____

Client Name (please print): _____

INFORMATION AND SUGGESTIONS

- Prior to your treatment please remove jewelry; pull long hair back with clip or band.
- Massage is generally given while you are unclothed, however, you may wear undergarments or swimsuit.
- During your massage you will be covered with a sheet. Only the area being worked on may be exposed.
- Your therapist is highly trained. You may ask your therapist questions before, during, and after your treatment.
- Therapists are generally trained to keep the talking to a minimum (only when asking questions).
- Natural Oils and lotions are used for services. Please let therapist know if you are sensitive to anything