New Member Information

Date:____________________________

Name:____________________________________ Birth Date:_______________ Age:_________

Address:____

City:_________________________________ State:______ Zip:___________________________

Phone: _____________________________________ May we text you? Y N

Email:____

Occupation/Job Duties:

____

How did you find us? Please circle any that apply.

Friend (Who can we thank?____)

Web Social Media Drive By Other

Emergency Contact:____

Relationship:__________________________________ Phone:_____________________________

True Health Massage

Terms of Acceptance

Please read the following carefully before receiving any massage therapy. At True Health Massage, massage therapy is for the purpose of relaxation, stress reduction, and pain reduction. True Health Massage does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy. Massage therapy is not a substitute for medical care and True Health Massages recommends that you work with your primary caregiver for any condition you may have. Upon signing this form, you acknowledge that you have stated all known physical conditions and medications, and will keep True Health Massage updated on any changes. True Health Massage has provided this form as a reference and is not held liable for any services provided. True Health Massage DOES NOT accept any health, accident insurance, personal injury, workman's compensation, or any other type of insurance, or fill out any forms associated with insurance, including Medicare and Medicaid. Massage treatments made at True Health Massage are considered "Wellness" or "Maintenance" care, and are not covered by insurance even if the policy covers massage care.

I understand the above statements and accept massage therapy care on this basis.

Signature:____ Date:_________________________

(Continued on back side)

Health History

Reason for coming to our office:

____

____

Do you take any drugs/medications? Yes No

If yes, please list:

____

Have you had any major illnesses or diseases? (Ex. Cancer, stroke, heart disease)

Yes No

If yes, please list:

____

Have you ever had surgery? Yes No

If yes, please list:

____

Have you had a fall - accident - injury? Yes No

If yes, please list:

____

Do you have any sensitivity to heat or cold? Yes No

Do you have any allergies or skin conditions? Yes No

If yes, please list:

____

Are you pregnant or nursing? Yes No

Please describe your level of stress (0-10) _________

Please describe your level of pain (0-10) _________

Have you seen a massage therapist before? Yes No

How long?_______________________ Types of massage: ______________________________

Reason for stopping: ____

Anything else to add?____

____

____