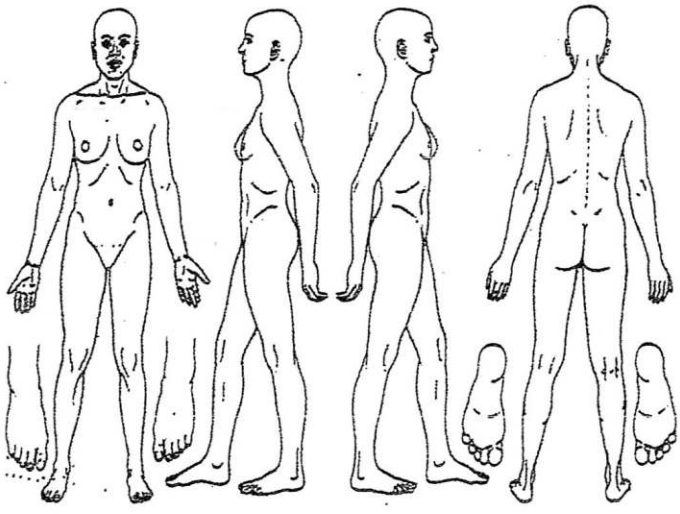
Patient Information

Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work/Cell Phone: _____
E-mail: _____ Occupation: _____
Are you currently under a physician's care for an acute or chronic illness? Y___ N___
If yes, please explain: _____
If yes, who is your health care provider? _____
Are you currently taking any prescribed medications or dietary supplements? Y___ N___
If yes, please explain: _____
Have you received Massage Therapy or Bodywork before? Y___ N___
If yes, what kinds: _____ How often? _____
How did you hear about me? _____
What are your goals this session? Sports Enhancement ___ Pain Reduction ___ Relaxation ___
Have you had any serious chronic illness, operations, or traumatic accidents? Y___ N___
If yes, please explain: _____
_____
Have you received any cortisone injections for low back pain? Y____ N_____
Do you exercise? _____ How many times per week? _____ Duration of workouts _____
Participate in sports? _____ How many times per week? _____ Duration of sport _____
Do you experience pain/discomfort when you work out? _____

Health History: check the following conditions that apply to you, past and present.

- ☐ Headache/Migraines
- ☐ Spasms/cramps
- ☐ Broken/fractured bones
- ☐ Sprains/strains
- ☐ Neck pain
- ☐ Pain between the shoulder blades
- ☐ Mid/Low back pain
- ☐ Hip pain
- ☐ Shoulder, arm, hand pain
- ☐ Leg/knee/foot pain
- ☐ Chest/rib/abdominal pain
- ☐ Jaw pain
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Bulging/herniated disks
- ☐ Bone or joint disease
- ☐ Breast augmentation
- ☐ Pacemaker
- ☐ Pregnancy: ☐ Current ☐ Previous
- ☐ Automobile accident: date of _____
- ☐ Surgeries _____
- ☐ Rheumatoid arthritis
- ☐ Multiple Sclerosis
- ☐ Guillain-Barre' Syndrome
- ☐ Low back cortisone injections
- ☐ Osteoporosis drugs, Boniva, Fosamax, Reclast
- ☐ Received the antibiotic Levaquin
- ☐ Other _____

Circle the areas on the figures below where you currently have pain. Shade THE most painful area.



Describe your pain. _____
_____
_____
_____
_____

Describe mobility issues. _____
_____
_____
_____
_____

see page 2 ↓

AUGUSTA ORTHOPEDIC MASSAGE LLC. / THE PAIN STOPS HERE

Massage Therapy/Bodywork Informed Consent

(Sign for Massage Therapy)

I, _____, (client) understand that massage is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience to touch.

(Sign for Rossiter Workout)

I, _____, (client) understand that Extreme Performance Bodywork (aka Rossiter) reduces/eliminates structural pain caused by restricted connective tissue, and increases range of motion.

The general benefits of massage, possible massage/bodywork therapy contraindications and the treatment procedures have been explained to me. I understand that massage/bodywork therapy is not a substitute for medical treatment or medications, and it is recommended that I concurrently work with my Primary Caregiver for any condition i may have.

I understand that massage/bodywork therapy is non-sexual

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/bodywork therapy.

Client Signature _____ Date _____/_____/_____

POLICIES

Cancellations

Your business is valued and your cooperation is appreciated. I am making a commitment to you to guarantee your appointment time and refusing all other requests once you have made an appointment.

A 12-hour cancellation notice is required for any scheduled appointments including gift certificates sessions. Missed or no-show appointments will result in your being charged the full amount of the session booked and I agree to pay any missed appointment fee.

I understand that if the massage therapist starts a session late, he will make up the time at the end of your session if possible, or will reduce his fee accordingly. I understand that if I arrive late, my session will end at the original scheduled time so the client following me is not penalized: Full payment is required. Emergency cancellations are determined by the Massage Therapists discretion.

Client Signature_____ Date _____/_____/_____