Sacred Grove Healing Massage

David Peter Armentano L.M.T., M.M.P.
License Number- MT111247
Phone Number: (469) 309-8243

Client Information

Name: _____ Home Phone: _____

Address: _____ City/State/Zip: _____

Cell phone: _____ Work Phone_____

Birth Date____/___/____ Email: _____ (we don't share email)

How did you hear about us: Dr._____?
Website: _____ Yellow Pages: _____ Other (Please explain): _____
Web Address: _____
Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

What is your reason for today's visit? (ex: relax, specific discomfort/pain)

_____

Have you ever had a professional massage before? Yes___ No___
Are you pregnant or trying to get pregnant? Yes___ No___
If yes, how far along are you? _____

PLEASE MARK IF YOU HAVE/HAD ANY OF THE FOLLOWING CONDITIONS:

Heart Condition	High Blood Pressure	Stomach Disorders
Skin Disorders	Immune Disorders	Respiratory Disorders
Diabetes	Cancer	Broken Bones
Arthritis	Allergies	Neck/Shoulder Pain
Headaches	Back/Chest Aches	Edema
Sciatic Pain	Leg/Foot Pain	Wear Contacts
TMJ Syndrome	Neuropathies	Spinal Disc Problems
Breast Augmentation	Dentures	Sprain/Strain
Allergies (Oils/Scent)	Vascular/Blood Disorders	Surgery (90 days or Less with Doctor's release)
Radiation\Chemo Therapy How Long?		

Do you Smoke? _____ Drink Alcohol? _____ Drink Caffeine? _____
Drink Soda? _____ Eat Chocolate? _____ Use lots of salt? _____
Exercise/ Stretching Habits? _____
How many times per week? _____ Duration? _____

Please advise us of any other health care professionals you have seen for this condition_____

Do you take any prescription medication? _____ if yes please list:
_____

Do you have any other medical issues including surgery that I should be aware of before giving you massage therapy? If yes, please describe._____

Please read the following, initial and sign below:

___ I consent to Breast Massage of female clients if it is medically necessary and/or requested. **This is not required**. If you are uncomfortable with this write no in initial line.

___We utilize conservative draping during our sessions.

___If you feel uncomfortable for any reason you may ask to end the session.

___The types of techniques your therapist will use in the session, the parts of the body to be massaged, including indications /contraindications are determined during your initial visit / assessment and are fully explained by your Therapist.

___ Be aware that your therapist is a Licensed Massage Therapists with a wide variety of Advanced Training. However, your therapist is not a licensed physician if you have specific questions regarding your health beyond the scope of massage please seek the advice of your physician

___ I understand that Massage Therapy given here is for the purpose of, but not limited to: Fulfilling a prescription of a treating physician, for a medically necessary condition. For stress reduction, relief from muscular tension, spasm or for increasing circulation and energy flow. I understand that the Massage Therapist does not diagnose illness, disease, or any other physical or mental disorder. Massage therapy is not a substitute for medical examinations and/or diagnosis. It is recommended that I see a physician for any physical ailment that I might have.

___Because a Massage Therapists must be aware of existing physical conditions; I have stated all of my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

___ I will respect the time of my Massage Therapist(s) and other clients. I agree to come to my scheduled appointments promptly, barring any unforeseen emergency. I understand that if I cancel later than 4 hours prior to my appointment, I will have to pay **HALF** the cost of my appointment. If I **NO SHOW**, I will have to pay the **FULL** price of the appointment.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____