Advanced Therapeutic Massage

Application for Treatment **PLEASE PRINT LEGIBLY**

Full Name_________________________________Date of Birth________________________

Address____

City____State_______Zip____________

Primary Phone__________________________Alternate Phone_________________________

Employer______________________________Email Address___________________________

Reason for Treatment and Area(s) of Complaint______________________________________

Have you been treated for this condition before?_____________________________________

Are you under the care of another health care practitioner for this condition?_________________

If yes, Whom?_____________________________________Phone:____________________

NOTE: Therapeutic Massage is a non-sexual health care. In all massage modalities and sessions, draping will be used. Massage is a service intended for enhancing your health and quality of life. If at any time you are uncomfortable with the massage, please inform the therapist and he/she will gladly rectify the problem, including ending the session if you wish.

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List any health conditions or surgeries you have had in the last 5 years:

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Please list any medications and reason for taking them_____________________________

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Please list additional health issues or body regions not to be massaged:__________________

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Do you have allergies?__________Are you pregnant?____________Due Date____________

IF PAIN IS A FACTOR PLEASE COMPLETE THE FOLLOWING!

Is there pain with motion?_________When did it start?__________________________________

What makes it better?______________________What makes it worse?_________________

*All therapists at ATM have been trained in Swedish Massage and will be using this modality in its varying levels of pressure unless otherwise stated here.*__________________________________

VOLUNTARY

How did you learn about our services?____

I release Advanced Therapeutic Massage from any responsibility for pre-existing conditions I have not revealed or any consequential changes to those conditions that arise subsequent to the treatment. I understand that my healing process requires my active participation and I acknowledge that I choose to do so.

Client Signature:____Date___________

Therapist Signature:____Date___________