Debi A. Gaul, LCMT

CLIENT INFORMATION & RELEASE FORM

NAME _____ DATE _____

ADDRESS _____

CITY_____ STATE _____ ZIP _____

HOME PHONE_____WORK PHONE _____CELL_____

E-MAIL _____

DATE OF BIRTH _____OCCUPATION _____

REFERRED BY _____

EMERGENCY CONTACT_____TELEPHONE_____

Medical Information

Yes	**No**	
____	____	Are you wearing contact lenses?
____	____	Are you pregnant and if so how far? _____
____	____	Do you frequently suffer from stress?
____	____	Do you have any numbness or stabbing pains and if so, where? _____
____	____	Have you had any broken bones in the past two years, if so where? _____
____	____	Do you experience frequent headaches?
____	____	Are you sensitive to fragrances?

Have you ever had any surgeries, including cosmetic? If so, what type and list approximate dates.
_____

Are you currently taking any medications and for what condition? _____
_____

Please describe any current medical problems._____
_____

Check specific areas where you currently experience pain or discomfort:

____	Head	____	Arms	____	Knees	____	Neck
____	Hands	____	Lower Legs	____	Shoulders	____	Abdomen
____	Ankles	____	Chest	____	Pelvis	____	Feet
____	Lower Back	____	Middle Back	____	Upper Back	____	Hips

Have you had any of the following conditions? Please circle:

High Blood Pressure	Heart/Circulatory	Respiratory Disorders
Whiplash	Cancer	Osteoporosis
Neck/Spine Injury	Diabetes	Arthritis
Sports Injury	M.S.	T.M.J.D.
Skin Disorders	Infectious Conditions	Epilepsy

Any other conditions I should be aware of? _____

How is your sleep? _____ Do you exercise regularly?_____

Have you had a professional massage/bodywork session? _____

What did you like best about your session? _____

Is there anything you dislike in massage techniques? _____
_____

Do you have any allergies to lotions or oils?_____

Do you have specific areas you would like to work on? _____

Are there any areas that are particularly sensitive, painful or that you don't want me to touch?_____

Is it OK for me to massage your head and face? _____

What would you like to get out of today's session?_____

Please take a moment and carefully read the following information and sign where indicated.

The above information is accurate to the best of my knowledge. I understand that the massage therapist, while trained in MassageTtherapy, is not trained to diagnose or treat any form of illness, disease, or injury and that I will be receiving massage therapy as a form of adjunctive health care only, and that this therapy is not intended to replace appropriate medical care. I do forever release the therapists and their insurers from all liability of any nature whatsoever, whether past, present, or future for injury or damage which may occur as a result of my receiving massage therapy. I agree to hold harmless and defend the therapist of all actions, claims, or other legal or administrative action that has arisen or may arise from my participation in this therapy. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. I also understand that anything discussed during my session will remain confidential.

As a service oriented business, my clientele is important to me. As a professional I structure my time to meet the greatest need. In doing such I have set the following cancellation policy. If for any reason you cannot keep an appointment please call at least 24 hours in advance to reschedule. This will aid in filling your appointed time. If this policy is not upheld you will be charged for your missed appointment. Less than 24 hour notice will be billed at half of your normal hourly fee. For no shows (no prior notice) you will be billed at full fee.

Signed_____Date_____

Office Policies

Client Information

Client Name: _____ Date: _____ Date of Birth: _____

Please be advised of the policies for this office. Your signature below signifies acceptance of these policies.

Cancellation
A 24-hour notice is required for cancellation of an appointment, or you will be charged in full for the appointment. Payment is due before your next appointment.

Tardiness
Appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please be on time to your appointment.

Sickness
Massage/bodywork is not appropriate care for infectious or contagious illness. Please cancel your appointment as soon as you are aware of an infectious or contagious condition. If it is within the 24-hour notice period, the cancellation fee may be waived.
If this office is providing billing services, please be advised of our billing policies.

Cancellation
We do not bill insurance companies for missed appointments or late cancellations. You are responsible for paying the missed appointment/late cancellation fees.

Financial Responsibility
Once your insurance is verified, we will bill and accept payment from your insurance company for covered services. In the event that the insurance company denies payment or makes partial payment, you are responsible for the balance, deductibles, and co-pays. Your signature below confirms your financial responsibility for all services regardless of insurance reimbursement.

Assignment of Benefits
Your signature below authorizes and directs payment of medical benefits to the massage/bodywork practitioner for services provided by this office.

Release of Medical Records
Your signature below authorizes the release of all of your medical records on file in this office, for the purpose of processing your claims, to the following: your attorney, the healthcare providers attending to this condition, and the insurance case managers. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through your attorney.

Signature: _____ Date: _____