28469 US 19 N suite 402
Clearwater, FL 33761
(727) 786-1110

Thank you for choosing Therapeutic Elements Center for Massage Therapy for your Massage & Bodywork needs. Selecting a therapist is an important process, and we hope that you will be delighted with the service you receive.

The following policies are provided to you for your review and signature:

1. **Silence all electronic devices**.
2. Arrive 15 minutes before your scheduled appointment time.
3. If you are **late for your appointment**, the appointment still starts and ends at the scheduled time.
4. **Twelve (12) hours prior notice is required to cancel an appointment without a charge. Any other cancellations, at the therapist's discretion, will be billed at that that treatment's rate.**
5. In consideration of your Licensed Massage Therapist, you give Therapeutic Elements permission to hold an updated credit card on file and understand that we **hold the right to charge the full price of your scheduled massage treatment to the credit card on file in the event that you do not show up for your scheduled treatment.**
6. Effective April 1, 2018 All credit card processing fees are the responsibility of the client and will be due upon receipt.
7. If the session is terminated due to **inappropriate behavior or conduct**, **Payment is due in full.**
8. For the safety of you and your therapist, please disclose ALL information related to your medical conditions. **ALL INFORMATION IS STRICTLY CONFIDENTIAL**.
9. It is your obligation to update your therapist on your medications, medical conditions, and responses to the massage treatment.
10. **Please inform the therapist if the pressure during the massage treatment need to be adjusted to your comfort level**.

Client Signature: _____ Date: _____

Parent Signature (if client is under 18 years of age): _____

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Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Occupation: _____Yrs:_____

Phone: _____ Email: _____

Emergency Contact: _____ Phone: _____

Primary Physician: _____ Phone: _____

May we have permission to contact your Primary Physician and keep them informed of your progress?
Yes ☐ No ☐

1. Who can we thank for referring you? _____

The following information will be used to help plan safe and effective treatments. Please answer the questions to the best of your knowledge.

2. Have you ever had a professional massage before? Yes ☐ No ☐ Frequency _____

3. Do you have any difficulty lying on your front, back, or side? Yes ☐ No ☐ If yes please explain:
_____

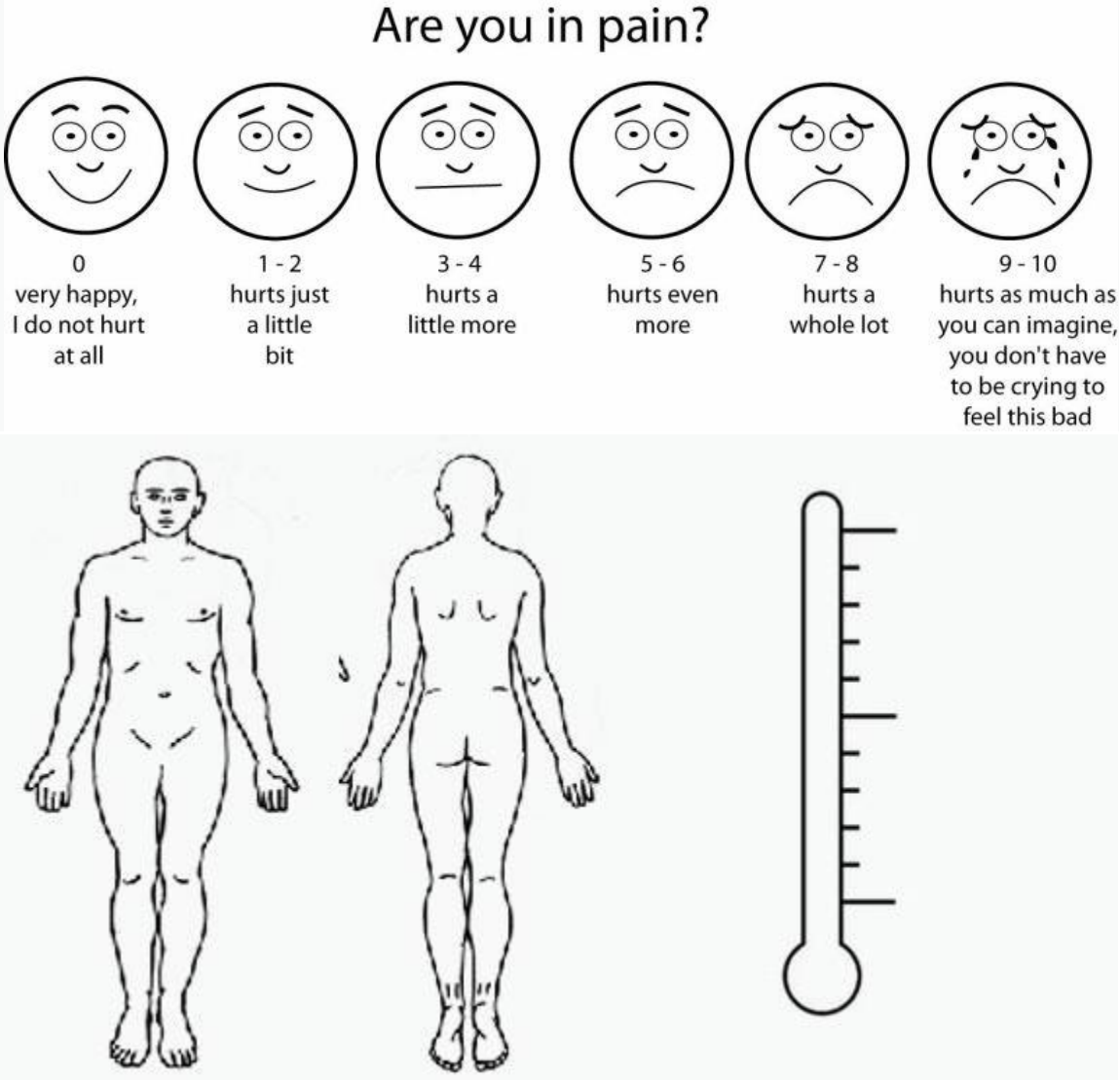
4. Do you have any allergies to oils, lotions or ointments? Yes ☐ No ☐ If yes please explain:_____
_____

5. Are you wearing: ☐ contact lenses ☐ dentures ☐ hearing aid

6. What specific goals are you looking to achieve from your massage treatment? _____

_____

7. Where exactly is the problem**?** Mark the figure below to specify. Rate the recent level of discomfort by shading in the thermometer below. (You may select more than one body part.)



8. Have you ever been treated for this same condition? Yes ☐ No ☐ If yes, please explain:_____

9. Were you admitted to the hospital? Yes ☐ No ☐

10. Describe how it feels:
(aching, cramping, dull, sore, deep, sharp, stabbing, stinging, tingling, burning, numbness, radiating -if so where?)

11. How did it start the first time and this time, if this is not the first?

(Sudden or gradual onset and mechanism of injury)

12. How often does it bother you?
(Constant, all the time, every day, number of times per week or month)

13. How long does it last once it is there?
(Always there, number of minutes or hours)

14. What specifically makes it worse?
(Certain movements/activities, stress, time of day, no pattern)

15. What makes it feel better?
(Certain movements/activities, heat/ice, time of day, therapies, nothing)

16. Do you have a diagnosis from a Doctor? Yes ☐ No ☐ If Yes, Please explain:_____

_____

_____

17. Other therapies/remedies tried and results:

Chiropractic

Orthopedics

Injections

Massage Therapy

Acupuncture

Medication

Other

18. Have you ever had any surgeries and were they beneficial at the time? _____

_____

19. List any other health problems for which you are being treated:_____

_____

20. Do you have any pre-existing conditions that relate to this present injury? Yes ☐ No ☐

If yes, please explain:_____

_____

21. Current Medications:_____

_____

Activities of Daily Living

In this section, the idea is to get a sense of what type and to what *intensity* and *frequency* of activities/movements, postures/positions, and exercise you get on a regular basis.

Job/Work Duties: Household Duties: Regular Activities/Hobbies

Exercise: Sleeping Position: Other:

22. What do you believe caused or is causing this condition? _____

_____

23. Do you believe it is possible to heal 100%? If not, what %? _____

_____

24. How long do you feel it will take? _____

25. On a scale of 0-10, how much effort are you willing to put in to achieve maximum healing?

_____

26. Select the level of stress you are experiencing on a regular basis on a scale of 1 to 10:

_____

Describe what positive impact would happen in your life if you were symptom free.
(Examples) Play with my children, play tennis/ basketball/ other sports, exercise, work, sleep better, etc.

_____

_____

_____

27. Please circle any of the following categories that we can help you with.

•Weight Loss •Inflammation •Skin Care •Energy •Sleep

Health History

Check the following conditions that apply to you, past and present. Please add your comments to clarify the conditions.

Musculo-Skeletal
- Headaches
- Joint stiffness/swelling
- Spasms/cramps
- Broken/fractured bones
- Strains/sprains
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Leg, foot pain
- Chest, ribs, abdominal pain
- Problems walking
- Jaw pain/TMJ
- Tendinitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone or joint disease
- Other:_____

Circulatory & Respiratory
- Dizziness
- Shortness of breath
- Fainting
- Cold feet or hands
- Cold sweats
- Swollen ankles
- Pressure sores
- Varicose veins
- Blood clots
- Stroke
- Heart condition
- Allergies
- Sinus problems
- Asthma
- High blood pressure
- Low blood pressure
- Lymphedema
- Other:_____

Skin
- Rashes
- Allergies
- Athlete's Foot
- Warts
- Moles
- Acne
- Cosmetic surgery
- Other:_____

Digestive
- Nervous stomach
- Indigestion
- Constipation
- Intestinal gas/bloating
- Diarrhea
- Diverticulitis
- Irritable bowel syndrome
- Crohn's Disease
- Colitis
- Adaptive aids
- Other:_____

Nervous System
- Numbness/tingling
- Twitching of face
- Fatigue
- Chronic pain
- Sleep disorders
- Ulcers
- Paralysis
- Herpes/shingles
- Cerebral Palsy
- Epilepsy
- Chronic Fatigue Syndrome
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's Disease
- Spinal cord injury
- Other:_____

Reproductive System
- Pregnancy:
  - Current • Previous
- PMS
- Menopause
- Pelvic Inflammatory Disease
- Endometriosis
- Hysterectomy
- Fertility concerns
- Prostate problems

Other
- Loss of appetite
- Forgetfulness
- Confusion
- Depression
- Difficulty concentrating
- Drug use:_____
- Alcohol use:_____
- Nicotine use:_____
- Caffeine use:_____
- Hearing impaired
- Visually impaired
- Burning upon urination
- Bladder infection
- Eating disorder
- Diabetes
- Fibromyalgia
- Post/Polio Syndrome
- Cancer
- Infectious disease (please list)
  _____
- Other congenital or acquired disabilities (please list)_____
  _____
- Surgeries:_____
- Other:_____

For clients who need mobility assistance, please give your Height:_____ Weight:_____

Please list any additional comments regarding your health and well-being:_____
_____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's Signature:_____Date:_____