MASSAGE AND BODYWORK

Jamie K. Lemmon *Licensed & Certified*

Balancing the Body, Mind & Spirit

12421 SE 221st Place, Kent, WA 98031 ♦ www.kentmassage.com ♦ 253-332-7318

Confidential Client Information

~~S.S. #~~ _____

Last Name: _____ First Name: _____ Birth date: ____/____/____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Alt. Phone: _____

Referred By: _____ Phone Number: _____

Employer: _____ Occupation: _____

Work Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: _____ Extension: _____

Emergency Contact: _____ Phone Number: _____

Relationship: _____

Physician: _____ Phone Number: _____

Health History:

Please List all Medications you are currently taking and for what purpose: _____

_____

Are you Pregnant? _____ How Many Weeks? _____

Have you ever had surgery? If so, when and for what condition? _____

Any recent injury or illness? What & When? _____ Hospitalized? _____

What do you want from your massage? _____

Areas needing special attention? _____

Please check any conditions that apply to you:

___ High Blood Pressure	____ Phlebitis	____ Varicose Veins	____ Sinus Congestion	____ Stress
___ Low Blood Pressure	____ Diabetes	____ Heart Trouble	____ Blood Clots	____ Fever
___ Contagious Condition	____ Cancer	____ Tumors	____ Seizures / Epilepsy	____ Cold / Flu
___ Ulcerated Colon	____ Neck / Spinal Injury	____ Scoliosis	____ Arthritis	____ Numbness
___ Headaches	____ Disc Problems	____ Stroke	____ Back Pain	
___ Skin Disorders	____ Athlete's Foot	____ Aids	____ Allergies	
___ Dentures	____ Muscle Tightness	____ Sprain / Strain	____ Contacts	

Financial Policy:
Payment is due at the time of each visit, unless other specific arrangements are made.

Cancellation Policy:
The time of your appointment is reserved for you. Please give 24 hours notice if you are unable to keep your appointment. Appointments cancelled less then 24 hours beforehand will be charged half the amount for the office visit (Emergencies will be handled on a case-by-case basis).

No Show Policy:
If you do not call and cancel your appointment, you will be charged the full amount of the time reserved for you. (Emergencies will be handled on a case-by-case basis). Insurance clients will be billed personally for missed appointments.

I understand that massage is given for the purpose of stress reduction, relief from muscular tension, spasm, pain, or for increasing circulation. I understand that Massage Practitioners do not diagnose illness, disease or any other physical or mental disorder. Nor do they prescribe medical treatment, pharmaceuticals, nor perform spinal manipulation. It has been made clear to me that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have. **I have stated all my known medical conditions and will keep my Massage Practitioner updated on my health.** By signing below I recognize and understand my responsibilities as a client.

Signature: _____ Date: _____