DEEP TISSUE SPOKANE

112 N UNIVERSITY RD, STE B106
SPOKANE VALLEY, WA. 99206
509-280-6720

CLIENT INFORMATION AND HEALTH HISTORY

PERSONAL INFORMATION

FIRST NAME________________LAST_________________DATE OF BIRTH*__________________
ADDRESS_____________________________ CITY ___________________ STATE _______ ZIP _______
PHONE(H)_______________________(C)________________________

EMAIL ADDRESS _________________________________ REFERRED BY___________________
IN CASE OF EMERGENCY CONTACT______________________PHONE____________________
RELATIONSHIP ____________________OCCUPATION___________________________________
IS IT APPROPRIATE TO CONTACT YOU REGARDING YOUR MASSAGE AT THE ABOVE NUMBERS? Y__N__ *For birthday specials only*

DO YOU SMOKE? Y__N__

MASSAGE EXPERIENCE IS THIS YOUR 1st PROFESSIONAL MASSAGE? Y__N__ IF NO, HOW FREQUENTLY DO YOU GET A MASSAGE?__________________WHEN WAS YOUR LAST MASSAGE?____

MEDICAL HISTORY DESCRIBE ANY SURGERIES, HOSPITALIZATIONS, ACCIDENTS OR INJURIES YOU HAD: LESS THAN 5 YEARS AGO:____
____
____

WHAT KIND OF CARE DID YOU RECEIVE FOR YOUR ACCIDENTS OR INJURIES?_____________
____
____

DO YOU FEEL YOU HAVE RECOVERED FROM THESE EVENTS? Y__N__ IF NO, PLEASE EXPLAIN:____
____

MEDICAL PROVIDER INFORMATION ARE YOU CURRENTLY/OR HAVE BEEN UNDER THE CARE OF A **PHYSICIAN**? Y__N__ IF SO, WHEN? ________WHO____________________________

PLEASE LIST REASONS____
____ARE YOU CURRENTLY/OR HAVE BEEN UNDER THE CARE OF A **CHIROPRACTOR**? Y__N__

IF SO, WHEN? __________________ PLEASE LIST REASON(S):__________________________
____

MEDICATIONS

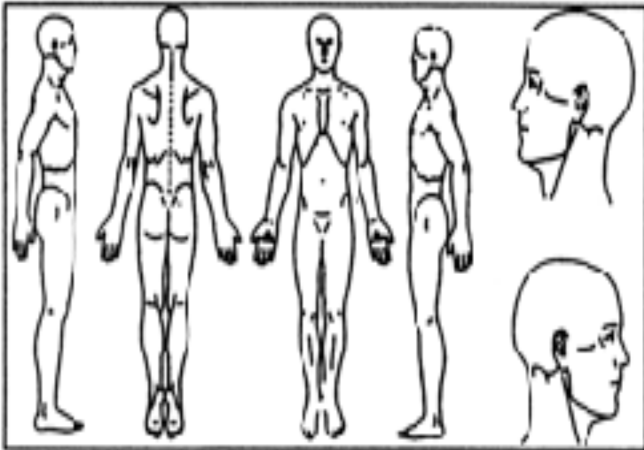
PLEASE LIST ANY MEDICATION (VITAMINS, HERBS OR PHARMACEUTICALS) TAKEN NOW OR AT REGULAR INTERVALS
(INCLUDE INFORMATION OF WHAT MEDICATION IS USED TO TREAT):______________________
____
____

CURRENT MEDICAL COMPLAINTS/CONDITIONS DO YOU HAVE ANY CHRONIC, ONGOING PAIN THAT YOU DEAL WITH ON A REGULAR BASIS?____
____

DESCRIBE WHAT ACTIVITIES CAUSE THIS PAIN AND/OR MAKE IT WORSE?_________________
________________________________ARE YOU RECEIVING ANY OTHER TYPE OF MEDICAL TREATMENT? Y__N__ PLEASE EXPLAIN:____
____

ARE THERE ANY OTHER HEALTH CONCERNS YOU WISH TO DISCUSS TODAY? Y__N__ IF YES, PLEASE DESCRIBE____
____

PLEASE SHADE IN WHERE YOU EXPERIENCE PAIN BELOW



THE ABOVE INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT MASSAGE THERAPISTS DO NOT DIAGNOSE DISEASE, PRESCRIBE MEDICATIONS OR MANIPULATE BONES. I FURTHER UNDERSTAND THAT MASSAGE THERAPY IS NOT A SUBSTITUTE FOR MEDICAL ATTENTION OR EXAMINATION. I TAKE RESPONSIBILITY FOR ALERTING MY PRACTITIONER TO ANY PHYSICAL, MENTAL OR EMOTIONAL CHANGES THAT OCCUR WITH MY HEALTH.

I ALSO UNDERSTAND THAT CANCELLED OR MISSED APPOINTMENTS WITHOUT 24 HOURS NOTICE WILL RESULT IN $65.00 CHARGE TOWARDS MY ACCOUNT. (MEDICAL or FAMILY EMERGENCIES or ILLNESSES EXCLUDED)

SIGNATURE______________________________

DATE___________________________________

REFERRAL INCENTIVE:

For every person who comes in based off your referral, you will receive $32.50 credit towards your account. Initials _____