Patricia Hopper, LMT
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CLIENT INFORMATION

Last Name ______________________________ Phone ______________________________

First Name ______________________________ Email Address ______________________________

Street Address ______________________________ Date of Birth ______________ Age ________

City ________________ State________ Zip ________ Occupation ______________________________

How did you learn about me? ______________________ Add me to email list ☐ Yes ☐ No

HEALTH HISTORY

Mark any condition that applies to you now or in the past. Please use "**C**" for current and "**P**" for past:

_______Allergy to Nut Oils
_______Arthritis
_______Artificial Joint
_______Blood Clots
_______Bruise Easily
_______Bursitis
_______Cancer/Tumor
_______Contact Lenses
_______Contagious Conditions
_______Decreased Sensation/Numbness
_______Diabetes
_______Fibromyalgia
_______Headaches/Migraines
_______Heart Attack/Stroke
_______High Blood Pressure
_______Hypo or Hyperglycemia
_______Low Back Pain
_______Low Blood Pressure
_______Muscle Sprain/Strain
_______Osteoporosis
_______Pregnant
_______Skin Infections
_______Trouble Sleeping/Insomnia
_______Varicose Veins
_______Other Conditions
____

Other relevant health history? ____

Accidents, Injuries or Surgeries:
In last five years: ____

More than five years ago: ____

Are you currently receiving medical or chiropractic care? ☐ Yes ☐ No

If yes, please explain: ____

Are you taking any medications (prescription or over the counter)? ☐ Yes ☐ No

If yes, please explain: ____

Do you exercise? ☐ Yes ☐ No

What type of exercise? ______________________________ How often? ______________________

Have you received massage before? ☐ Yes ☐ No

Policy Agreement
It is my choice to receive massage therapy, and I give my consent to receive treatment. The medical information I have reported is complete and accurate. I will notify my massage therapist of any changes in my physical condition prior to treatment. I understand that massage therapists do not diagnose illness, disease or any other physical or mental condition or prescribe medical treatment or pharmaceuticals.

I agree to inform my practitioner any time I feel my well-being is threatened or compromised. I will inform my therapist immediately of any pain or discomfort during a session. I understand that I have the right to refuse any treatment or to request modifications to in terms of pressure, depth or approach to treatment.

When I need to cancel or reschedule my appointment, I will contact my therapist at least 24 hours in advance. This time gives the therapist an opportunity to fill the opening. Failure to give 24 hours notice will result in a $65 cancellation fee.

Signature ______________________________ Date ____________________