BELLTOWN
SPINE & WELLNESS

Date ________________

Massage Therapy

Name: ________________________________ Home Phone: _________________ Work/Cell Phone: ________________

Address: ___________________________Apt #_______City: ________________State: ________ Zip: _____________

Date of Birth:________________ Age: _______ Gender: Female Male Marital Status: __________________________

Occupation:__________________________________Email Address: ____

Emergency Contact: __________________________Phone#: _________________ Relationship: ____________________

Who referred you to this office? _______________________ Have you had massage before? ________ Last visit: ________

Bodywork Session Goals/Areas of Complaint: ____

Please check all that apply:

Allergies	Contagious Diseases	Numbness	Stroke
Anemia	Diabetes	Osteoporosis	Surgery
Arthritis	Digestive Problems	Phlebitis	Trauma
Auto-Immune Disease	Epilepsy/Seizures	Radiating Pain	Temperature Sensitivity
Blood Clots	Headaches/Migraines	Sinus Problems	Tendonitis
Bursitis	Heart Condition	Skin Conditions	TMJ/Grinding Teeth
Cancer/Tumors	Hemophilia	Sleeping Disorder	Varicose Veins
Circulation Problems	High Blood Pressure	Spinal Problems/Scoliosis	Whiplash
Chronic Fatigue	Low Blood Pressure	Strains/Sprains	Other: ____________________
Contact Lenses	Muscle Spasms	Stiff Joints	

For Women: Breast Implants Menstrual Cramps PMS Pregnancy: Week ________

Please explain any checked answers: ____

____

Surgery in the past 4 years? (Please Explain) ____

____

Medications? ____

____

What other treatments are you receiving? ☐ Acupuncture ☐ Physical Therapy ☐ Chiropractic ☐ Naturopathic

☐ Water ____/day or week ☐ Alcohol _____/day or week ☐ Smoke _____/day or week

☐ Eat Red Meat ____/day or week ☐ Drink Caffeine: Coffee/Tea _____C/ day or week

Daily Activities: ☐ Sitting ______hrs ☐ Computer Work _____hrs ☐ On phone _____hrs ☐ Walking _____hrs

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Massage Policies

At Belltown Spine & Wellness we understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, snowstorms, and illness are just a few reasons why one might consider canceling an appointment. In our desire to be effective and fair to all of our clients and out of consideration for our therapists' time, we have adopted the following policies:

Cancellations

- **24 hour advance notice is required** when cancelling an appointment to allow another patient to book the appointment.
- If you are unable to give us 24 hours advance notice, **you will be charged a $35** late cancellation fee. This amount must be paid in full prior to your next treatment.
- On the other hand, if we are able to fill your time slot, **you will not be charged for that missed appointment**.

No-shows

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show". **You will be charged a $35** No Show fee and future service will be denied until payment is made.

***If appointment was made using a "free" or" bonus" massage, massage will be forfeited in lieu of $35 fee.*

Arriving late

If you are not present for your scheduled session during the first 15 minutes (unless having telephoned us you might be late), it will be construed by us that you are a "no-show", and that time slot will automatically become available for someone else. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment, regardless of the length of the treatment actually given, **you will be responsible for the "full" session**.

If you have an open **auto injury** or **workers compensation** claim, for every 15 minutes you are late, you will be responsible to compensate the therapist $20 to cover the time that we are unable to bill to the insurance company.

*Out of respect and consideration to your therapist and other customers, **please** plan accordingly and be on time.*

Patient Name: ____

Signature: ____ *Date:* _________________

Consent for minors

- All persons 18 years old and younger must have a signed consent from a parent or guardian prior to receiving massage.
- All persons 15 years old and younger must also have a parent or guardian present in the room during the first session with a new therapist.

I ___________________________ (parent/guardian), give permission for ____________________________ (minor) to receive massage therapy treatment at Belltown Spine & Wellness Center and agree to abide to the above policies.

Parent/Guardian Signature: ____ *Date:* ____________________