Val's Therapeutic Massage
www.connectingsoma.com
10015 Lake City Way NE, #432
Seattle, WA 98125
(206)601 6086

Please fill out all information as accurately and thoroughly as possible.
It is better that you give me what you consider too much information, rather than not give me enough information.

Name: _____
Address: _____
WK PHONE:( ) _____- _____ HM: ( ) _____-_____ CELL ( )_____-_____
Employer Name_____
Employer Adress_____
Email/URL: _____
Date of Birth:_____
Hobbies: _____
Emergency Contact and their relationship to you:
_____**ph. ( )_____-_____**
Were you referred by anyone? _____
What (specifically) would you like to receive from this massage?

Would you like me to focus on or stay away from any specific area?

Health Information:
<u>Do you have or are you any of the following (Please circle Y=Yes or N=No):</u>

Smoker Y / N	**Depression Y / N**	**Pregnant? Y / N**
Contagious Disease Y / N	**Irregular Sleep Y / N**	**Weight change Y /N**
High/Low Blood Pressure Y / N	**Allergies Y / N**	**Heart Conditions Y / N**
Epilepsy? Y / N	**Seizures Y / N**	**Diabetes Y / N**
Disk problem Y / N	**Varicose Veins Y / N**	**Cancer Y / N**
Nausea Y / N	**Dementia Y / N**	**Concussion/Head injury Y / N**
On medications Y / N	**Headaches Y / N**	**Sinus problem Y / N**
Muscle Spasms/Cramps Y /N	**Bone/Joint disease Y / N**	**Arthritis/Rheumatism Y / N**
Tendonitis Y / N	**Broken/Cracked Bone Y /N**	**Sprain/Strain Y / N**
Joint dislocation Y / N	**Skin Disorder Y / N**	**Jaw Discomfort? Y / N**
Digestive Problem Y / N	**Pelvic Inflamm. Disease Y /N**	**Back Y / N**
Blood Clots Y / N	**Lung Disease Y /N**	**Surgery Y / N**
HIV positive Y / N	**Neck Pain Y / N**	**Neuritis/Neuralgia Y /N**
Sciatica/Lumbago Y / N	**Fatigue Y / N**	**Anxiety Y / N**

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Are you currently suffering from any pain related to traumatic experience (i.e.: Car accidents, sports injuries, surgeries)? Y / N
If yes, briefly explain (what and when):

_____
_____
_____

Are you currently taking any medications or supplements (prescription and non-prescript)? Y / N
If yes, name(s) of medication(s) and how often taken:

_____
_____
_____

Do you have any conditions that may require a doctor's note? Y / N

Is it okay for me to contact your healthcare provider? Y / N If yes, please input info below.
Name:_____ Phone #: ( )_____-_____

What are you expecting from this massage session and following sessions?

_____
_____

When did you receive your last massage? What kind massage did you have?

_____
_____

I understand that the massage practitioner does not diagnose illness, which are physical or mental in nature. A massage practitioner does not prescribe medical treatment or pharmaceuticals. I understand that massage is not substitute for medical exams, and I will see a physician for any physical ailment that I have. I have stated to the best of my knowledge all medical conditions. I agree to update the massage practitioner on my health. I will keep scheduled appointments and bring to those appointments appropriate information relating to my health .I agree to pay $25.00 fee for first missed or canceled in less than 24 hours and $50.00 if I missed or canceled any other appointments in less than 24 hours. I understand that it is measure taken to allow somebody else to be scheduled for massage therapy. I assume financial responsibility of paying for all services rendered either through third party payers (insurers) or being personally responsible for any services not covered by insurance in case of insurance payment. I understand that insurance or I will pay all services in 60 days after receiving massage treatment. I understand that the processing of insurance claims is a service and does not relieve me of my financial obligation. I agree that massage practitioner may impose reasonable interest, late charges, cost and/or reasonable attorneys' fees should my account become delinquent. I understand that prices and rules subject to change and can be performed without notification.

Signature **Date:**