Advanced Therapeutics
Pain Relief & Wellness Center

visit our website:
www.triggerpoints.info

Jeff Widmann, LMT, CPT, RYT #1757
704-332-7700

Today's Date:

OFFICE USE ONLY

Massage Therapist: _____

Type of massage provided: _____

SESSION NOTES:

☐ Tip online

Massage Intake Form — Confidential Information. Please fill-out, print and bring this form to your appointment.

Welcome. Thank you for taking the time to provide this information. I would like to make your appointment as pleasant and comfortable as possible, so if at any time you have questions regarding your session, please let me know.

Name _____ Date of birth _____

Address _____

email _____ **providing your email address subscribes you to our specials and discounts mailing list. Thank you!**

City _____ State _____ Best number to be reached _____

☐ check if prefer email contact

Occupation _____ Best time to call _____

Have you ever received massage therapy? ____ Yes ____ No

Type of massage experienced (swedish, shiatsu, deep tissue, etc.): _____

Are you currently taking any medications? ____ Yes ____ No

If yes, please list name and reason for medications): _____

_____

Are you currently seeing a healthcare professional? ____ Yes ____ No If yes, please list names and reason/treatment: _____

_____

Please review this list and check those conditions that have affected your health recently or in the past. Place an "X" to the condition.

____ arthritis
____ diabetes
____ blood clots
____ broken/dislocated bones
____ bruise easily
____ cancer
____ chronic pain
____ constipation/diarrhea
____ auto-immune condition*
(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)
____ hepatitis (A, B, C, other)
____ skin conditions
____ stroke
____ surgery
____ TMJ disorder
____ depression, panic disorder, anxiety, other psych condition
____ diverticulitis
____ headaches
____ heart conditions
____ back problems
____ high blood pressure
____ insomnia
____ muscle strain/sprain
____ pregnancy
____ scoliosis
____ seizures
____ whiplash
____ chemical dependency (alcohol, drugs)

If any of the above needs to be detailed or if there is anything else to share, please do so: _____

_____

Do you have any of the following today:

____ skin rash ____ cold/flu ____ open cuts ____ severe pain ____ anything contagious ____ injuries/bruises

Do you have any allergies to:

____ medications ____ foods (nuts, etc.) ____ environmental allergens (dust, pollen, fragrances)

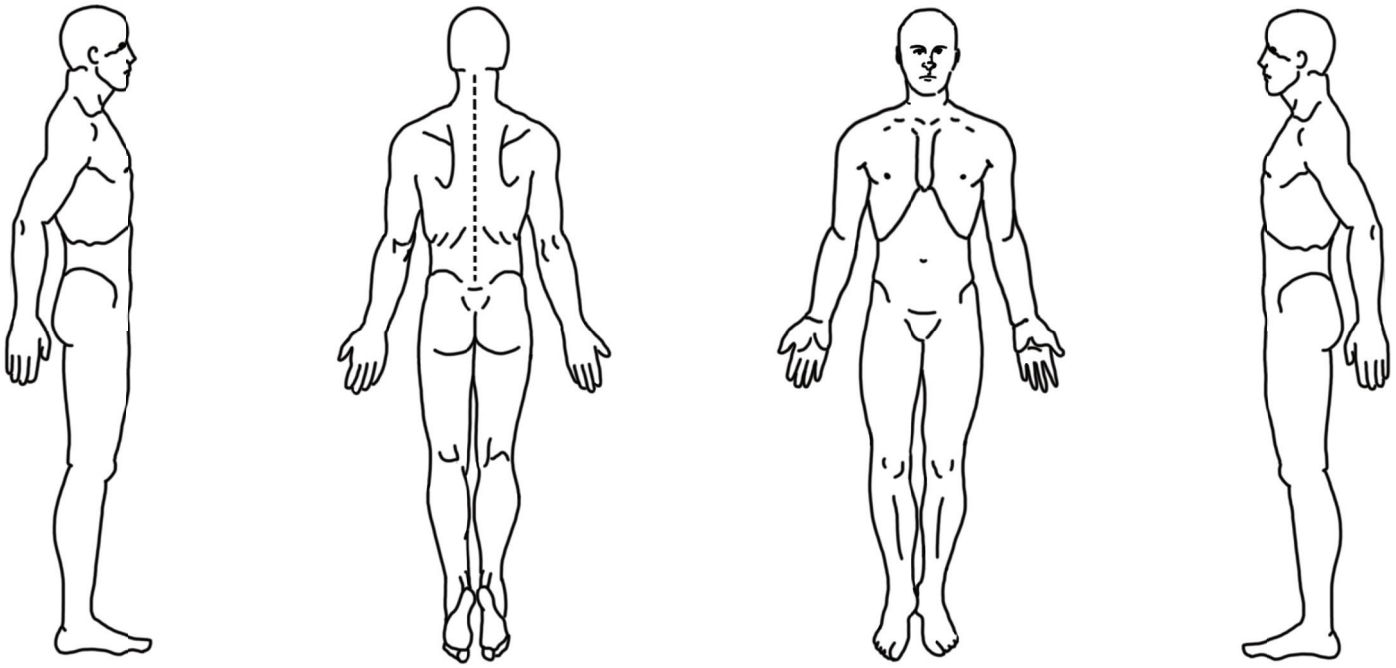
____ reactions to skin care products

If any of the above are checked, please give details: _____

_____

Are you wearing: ____ contact lenses ____ hearing aid ____ hairpiece

Please shade in to indicate, if any, the areas in which you are feeling discomfort (print out form):



What are your goals/expectations for this therapy session? _____

_____

_____

_____

_____

Please read the following information, print out and sign below. Bring this form to your appointment:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.
3. I agree to abide by a 24 hour cancellation notice for any scheduled massage. I understand that I will be charged the full amount of service for missed appointments or for any cancellations with less than a 24 hour notice. I understand that if I arrive late for an appointment, the session will end at the original scheduled time to prevent penalizing another client.
4. We will happily accept checks, cash *and* credit cards through our website at www.triggerpoints.info *Thank you*.

Signature: _____ Date _____

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Agreement of Release and Waiver of Liability

Advanced Therapeutics Pain Relief and Wellness Center

I, _____, hereby agree to the following:

1. That I am participating in the Fitness, Yoga classes, Health Programs, Massage Therapy or Workshops offered by **Advanced Therapeutics Pain Relief and Wellness Center**, during which I will receive information and instruction about yoga and health. I recognize that fitness training and classes and yoga require physical exertion that may be strenuous and may cause physical injury, and I am fully aware of the risks and hazards involved.

2. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in the Fitness, Yoga classes, Health Programs, Massage Therapy or Workshops. I represent and warrant that I am physically fit and I have no medical condition that would prevent my full participation in the Fitness, Yoga classes, Health Programs, Massage Therapy or Workshops.

3. In consideration of being permitted to participate in Fitness, Yoga classes, Health Programs, Massage Therapy or Workshops, I agree to assume full responsibility for any risks, injuries or damages, know or unknown, which I might incur as a result of participating in the programs.

4. In further consideration of being permitted to participate in Fitness, Yoga classes, Health Programs, Massage Therapy or Workshops, I knowingly, voluntarily and expressly waive any claim I may have against **Advanced Therapeutics Pain Relief and Wellness Center** for injury or damages that I may sustain as a result of participating in the programs.

5. I, my heirs or legal representatives forever release waive, discharge and covenant not to sue **Advanced Therapeutics Pain Relief and Wellness Center** for any injury or death caused by my negligence or other acts. I have read the above release and waiver of liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above.

_____ _____

Date Signature of Participant

_____

email

providing your email address allows us to send you specials, coupons and updates. Thank you.