Advanced Therapeutics
Pain Relief & Wellness Center

Appointment Checklist

what to expect today

Welcome to **Advanced Therapeutics**. We strive to provide the best Massage Therapy Services. Help us by reviewing the following:

☐ You have reserved a specific time-slot on our therapist's schedule. Unfortunately, if you are late, we cannot extend your appointment. *Filling out paperwork in advance is helpful.*

☐ Your therapist will meet briefly with you prior to your massage to introduce themselves, review your paperwork, discuss concerns and manage expectations. (example: any specific issues, allergies or preferences).

☐ Existing clients cannot use/redeem 3rd-party coupons or specials (ex.: Groupon). New client specials through these vendors can be used once in a lifetime.

☐ Many people ask for guidance on tipping. Therapists depend on tips as part of their compensation. It is customary to tip $20+ per therapist for :60 appointment.

_____
initial

Thank you

 • 801 Baxter Street, Suite 410, Charlotte, NC 28202 | **massageandyoga.center** | 704-**332-7700**

Advanced Therapeutics
Pain Relief & Wellness Center

visit our website:
www.triggerpoints.info

Jeff Widmann, LMBT, CPT, E-RYT #1757
704-332-7700

Today's Date:

OFFICE USE ONLY

Massage Therapist: _____

Type of massage provided: _____

SESSION NOTES:

☐ Tip online
Amount: $_____

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 _____

Occupation _____ Best time to call _____ ☐ check if prefer email contact

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. Check conditions that apply:

- ☐ 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)

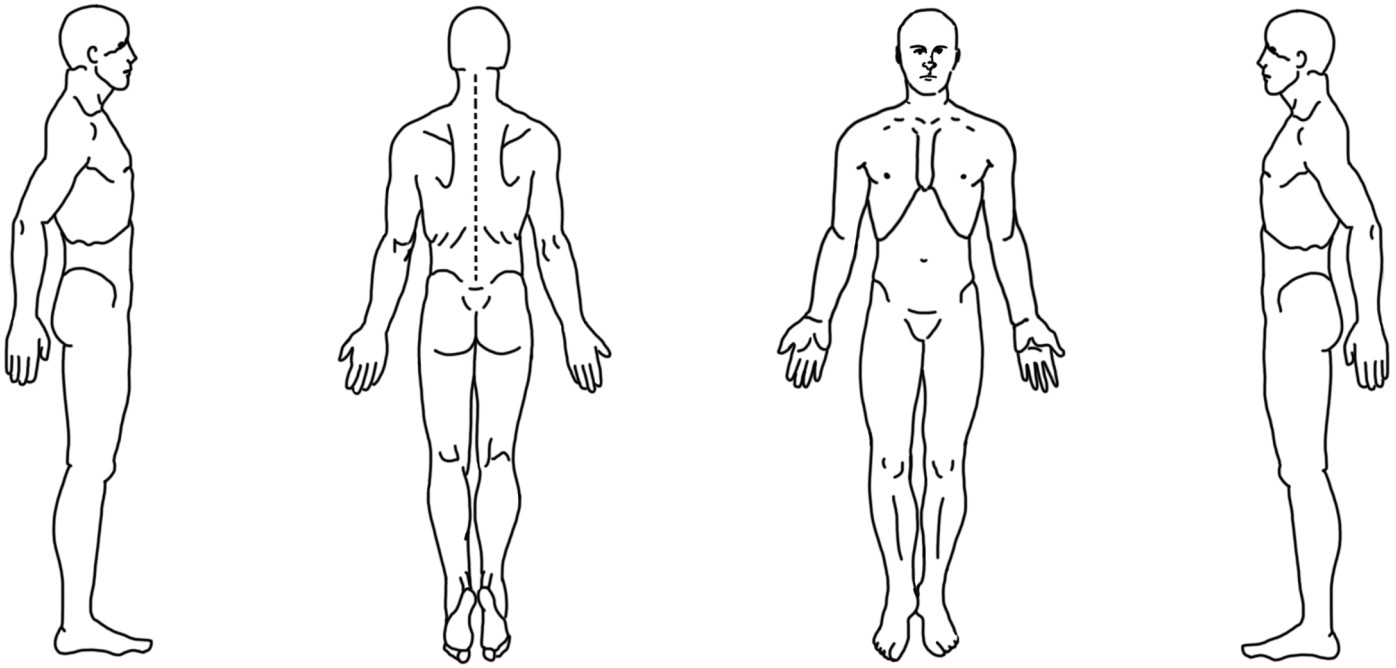
☐ reactions to skin care products

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 **massageandyoga.center** *Thank you*.

Signature: _____ Date _____

Advanced Therapeutics
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visit our website:
yogaandmassage.center
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Agreement of Release and Waiver of Liability

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.

6. Do you have a Fever OR Cough OR Shortness of Breath? ☐ YES ☐ NO

If yes, is there another reason for fever? Or at least two of these symptoms: DIARRHEA HEADACHE CHILLS SORE THROAT MUSCLE PAIN NEW LOSS OF TASTE/SMELL REPEATED SHAKING AND CHILLS

In the last 14 days have you had any contact with a COVID-19 positive patient, as far as you know or someone awaiting test results? ☐ YES ☐ NO

Date Signature of Participant

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

_____