



Appointment Date

Confidential Client Information

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Preferred method of contact (Circle): Phone - Home/Work/Cell or Email

How did you hear about us? _____

Please circle any of the following that pertain to you:

- | | | | |
|---------------------|----------------|---------------------------|----------------------|
| Seasonal Allergies | Migraines | Chronic Fatigue Syndrome | Celiac Disorder |
| Hypoglycemia | Headaches | Compromised Immune System | HIV/AIDS |
| High Blood Pressure | Insomnia | Osteoporosis | Liver Disorder |
| Heart Disease | Depression | Muscle Cramps | Plantar Fasciitis |
| Kidney Dysfunction | PMS | Carpal Tunnel Syndrome | Sciatica |
| Varicose Veins | Phlebitis | Digestive Disorders | Respiratory Disorder |
| Spine/Neck Injury | Stroke | Rheumatoid Arthritis | Thyroid Disorder |
| Fibromyalgia | Osteoarthritis | Diabetes | Gout |
| TMJ Syndrome | Cancer | Flu/Cold/Fever | Nerve Damage |
| Eczema | Psoriasis | Dermatitis | Tendinitis |

Please list any injuries (auto, sports, etc.) and their dates: _____

Please list any surgeries and their dates: _____

If you are pregnant, how many weeks? _____ Due Date: _____

Please list any other conditions for which you are being treated or seeking treatment: _____

Please list any medications or supplements you are currently taking: _____



What brings you in for massage today? _____

Do you have any goals for today's session? _____

Have you had therapeutic massage before? YES / NO

Do you have sensitivity to scents or essential oils? YES / NO

James River Massage Therapy, LLC Policies

- We charge \$25 for appointments that are missed or canceled less than 24 hours before the appointment time.
- We charge \$35 for returned checks.
- Coupons and Gift Certificates must be presented at the time of the appointment.
- Late clients will happily be seen, but appointments will end at the original scheduled time.
- Your treatment will not be discussed with any other party without your written and expressed consent.
- We will gladly provide itemized receipts upon request for submission to Health Savings Plans or special insurance reimbursement plans.
- We accept cash, checks, VISA and MasterCard.

I understand that if I experience any pain or discomfort during my session, I will immediately inform the therapist. I also understand that massage should not be considered a substitute for medical examination, diagnosis or treatment and I agree to seek qualified medical care for any mental or physical illness that I am experiencing. I recognize that massage therapists, though certified, are not licensed health care professionals and are not qualified to diagnose, treat or prescribe for illness or injury and I will request a referral if such is required. I also understand that certain contraindications exist for massage therapy and I will inform my massage therapist immediately if any changes to my health profile occur. I agree that my massage therapist will not be held liable for any negative effects if I fail to update my profile or provide complete information. Finally, I understand that any illicit or sexually suggestive remarks or advances will not be tolerated and will result in the immediate termination of the session with full payment due.

Client Signature: _____ Date: _____

Parent Signature (required if client is under 18): _____