Karla Rice, LMT (NVMT 6591)
(775)287-2737
kzrice69@yahoo.com

Please print clearly & legibly!!

Client Name:_____ M/F DOB_____ Date_____

Home Ph: _____ Cell Ph: _____Texting: Y N

Address_____

Occupation_____Email_____

Emergency Contact:_____ Phone:_____

My General Wellness is: __Good __Fair __Poor How Often do you exercise per week _____

Hobbies_____ Last

Chiropractic treatment _____ Reason_____ Result_____

How did you hear about me or who can I thank for the referral: _____

What do you want to accomplish today with your massage?_____

Health Information:

The information on this questionnaire will assist me with your massage as your therapist. All information is kept confidential.

Please answer truthfully and circle all that apply:

Skin Rash	Seizures	Diabetes	Bursitis
High/Low Blood Pressure	Fainting	Osteoporosis	Numbness/Tingling
Heart Conditions	Dizziness	Whiplash	Disk Problems
Chest Pain	Light Headed	Stiff Neck	Ticklish Feet
Phlebitis/ Blood Clots	Asthma	Headaches	Sciatica
Bruise Easily	COPD	TMJ/Teeth Grinding	Hip/Knee Replacement
Cancer:_____	Implants	Trauma (just let me know what areas to avoid)	

Are you want info Breast Massage or undraped glutes work? _____

Any pain with movement: Y N Have you seen a doctor for the pain? Y N Results? _____

Any Allergies: (Oils, Nuts, Seeds, Medications, Etc.) _____

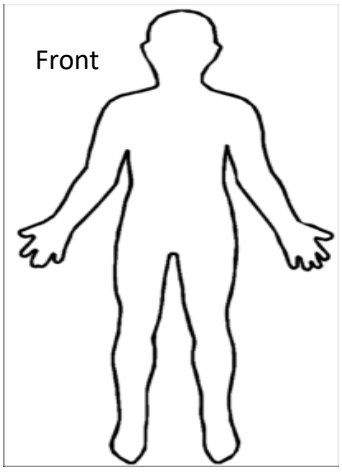
Any Injuries, broken bones, or surgeries?_____

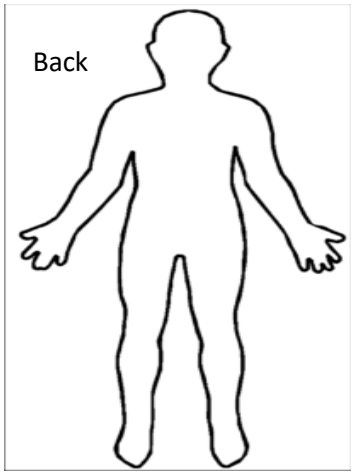
Medications: (prescription & nonprescription)_____

_____

Females: Are you Pregnant? Y N; If so how far long? _____ Are you considered high risk? Y N

Circle problem areas:





Client Release Form

I understand this information will be treated confidentially.

I understand the massage therapy given is for the purpose of stress reduction, relief from muscular tension, spasm, or for increasing circulation and energy flow. If I experience any pain or discomfort during this session, I will immediately inform the therapist. In order to maximize the effectiveness and safety of massage sessions, I agree to give feedback during and at the end of my sessions. I understand that I will need to update my therapist on my health and well-being prior to each session.

I understand that massage therapy is a therapeutic health aid and is **non-sexual**. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. I understand that information exchanged during any massage session is educational in nature and is intended to help me become more familiar with and conscious of my own health status and is to be used at my own discretion. Initials: _____

I understand massage is designed to be a health aid and is in no way to take the place of a doctor's care when a doctor's care is indicated. I understand that a massage therapist does not diagnose illness, disease, or any other physical or mental disorder. I understand that a massage therapist does not prescribe medical treatment or pharmaceuticals or perform any spinal manipulations. It has been made clear to me that massage therapy is not a substitute for medical examinations and/or diagnoses and that it is recommended that I see a physician for any physical ailment(s) that I might have.

I affirm that I have stated all my known medical conditions and have answered all questions honestly. I understand that there shall be no liability on the practitioner's part should I forget to do so.
Please be advised of the policies for this office. Your signature below signifies acceptance of these policies.

Arrival/Waiting room: There is a waiting room with one chair. Please walking in if the door isn't locked and take seat. Please DO NOT bring visitors with you.

Cancellation Policy: We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all clients, the following policies are honored. Due to the like hood of that appointment being filled there has been a few changes:

48 hours cancellation: You will be charged 25% of the service being cancelled.

24-hour cancellation: You will be charged 50% of the service being cancelled

No-shows and Same Day cancellations: You will be charge 100% of the service missed/late cancelled. Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show." They will be charged for their "missed" appointment. Unless you communicate reason of why you missed appointment like: ER, Family Emergency etc.

Late Arrivals: If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. 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 given, **you will be responsible for the "full" session**. Out of respect and consideration to your therapist and other customers, **please** plan accordingly and be on time.

Sickness: Massage/bodywork is not appropriate care for infectious or contagious illness. Please cancel your appointment as soon as you are aware of an infectious or contagious condition or not feeling well. If it is within the 24–48-hour notice period, the cancellation fee may be waived with reasonable notice

Cancellation: You are responsible for paying the missed appointment/late cancellation fees (this is for NO CALL NO SHOWS). Cards will be required to have on file starting 5/1/22 for this.

Release of Medical Records: The outside office will need your written consent from you to get your records

Client Name (please print) _____

Client Signature_____Date_____

Massage Therapist _____Date_____