

# Maria Elena Perez Massage Therapy

410 South Melrose Dr. Ste 200 Vista, CA 92081

## Confidential Information

Welcome. We want to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your visit, please let us know.

Name \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Email \_\_\_\_\_

DOB \_\_\_\_\_ Marital Status \_\_\_\_\_

Occupation \_\_\_\_\_

Referred by \_\_\_\_\_

\* Would you like to Receive Promotional Discounts?      YES      NO

• Have you ever received Massage Therapy?      Yes      No

• Type of Massage Received:    Swedish    Deep Tissue    Other \_\_\_\_\_

• Last Massage Therapy Session \_\_\_\_\_

• What are your expectations for a Massage? \_\_\_\_\_

• Are you taking medication? If so, for what condition? \_\_\_\_\_

• Are you pregnant?      Yes      No

### Do you have a history of the following?

\_\_\_ Neck Pain

\_\_\_ Whiplash

\_\_\_ Headaches

\_\_\_ TMJ

\_\_\_ Mid Back Pain

\_\_\_ Low Back Pain

\_\_\_ Scoliosis, Lordosis, Kephosis

\_\_\_ Decreased Range of Motion

\_\_\_ Disc Problems

\_\_\_ Joint Ache

\_\_\_ Sprain

\_\_\_ Chronic Pain \_\_\_\_\_

\_\_\_ Surgical Implants (Screws/Rods)

\_\_\_ Auto Immune Disorder

\_\_\_ Arthritis, Bursitis, or Gout

\_\_\_ Varicose Veins / Blood Clots

\_\_\_ Heart Condition

\_\_\_ HIV or Hepatitis

\_\_\_ Seizures

\_\_\_ Diabetes

\_\_\_ Stroke

\_\_\_ Cancer

\_\_\_ Allergies to Oils or Perfumes

Explanation of any Conditions above, Injuries, Surgeries or Prior Broken Bones:

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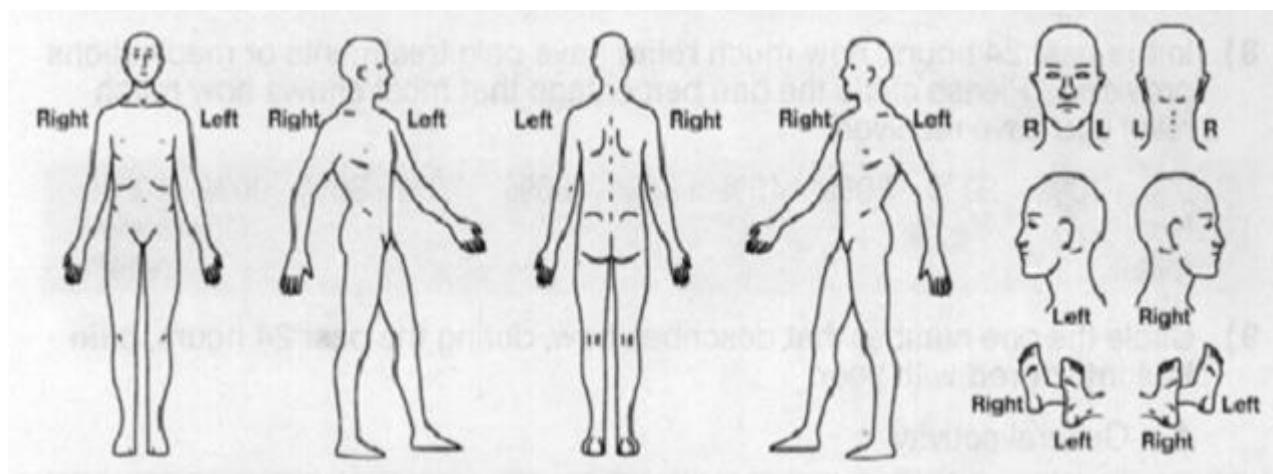
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**Do you have any of the following today?**

- Sunburn
- Inflammation
- Severe Pain
- Open Cuts, Bruises, Burns or Rash
- Cold/Flu

Other: \_\_\_\_\_

**Please indicate with an X the places you are feeling discomfort.**



**Scope:** I have completed this form to the best of my knowledge. I agree to keep the massage practitioner updated to any changes in my medical profile and understand that there shall be no liability on the practitioners part should I forget to do so. I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes can be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for a medical examination, diagnosis, or treatment. I will see a physician, chiropractor, or other qualified medical specialist for any mental, physical, or emotional ailment that I am aware of. Nothing said during the massage session will be construed as such.

**Cancellation:** I agree to give 24 hours notice for sessions I cannot keep. I am aware I may be charged in full for any session I miss without giving 24 hour notice to cancel or reschedule.

**Consent:** I, as a patient, consent to massage therapy at Maria Elena Perez Massage Therapy. I consent to maintain the confidentiality of any other patients within the facility and not disclose to anyone anything discussed at the facility by anyone other than myself. In accordance with HIPAA, your information is private and confidential. Only team members of the ProRehab Integrated Healthcare Specialists that are working directly with your care will share any information.

**NOTICE of Private Practices / Businesses and Patient’s Freedom of Choice**

There are separate practices within this office. Each entity is owned and operated as separate businesses and may have separate fee schedules and different treatment techniques. I understand that each service offered at this facility are owned and operated as separate businesses and hold each business harmless from any act of omission which may occur by any of the other businesses during the course of my treatment at this facility. Circumstances may arise, such as emergencies, vacation, or sick leave, and you may request to be treated by another practitioner within this office. If you are treated by another specialist, you may be charged a different fee. Patients are free to choose any doctor and organization that may be recommended by our team. You do not have to use the facilities at our office for treatments and we can assist you on finding an alternative location or resources.

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**Signature**

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**Date**