Star Healing Touch 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:

_____

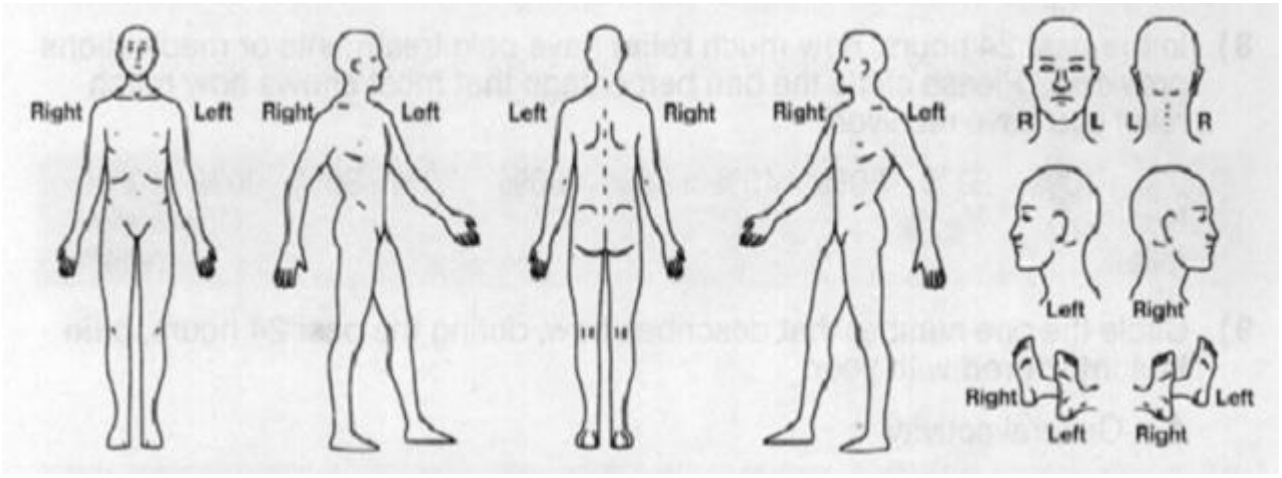
_____

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.

Cancelation: 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 Star Healing Touch 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.

_____ _____

Signature **Date**