KAMALA, THE CENTER FOR RADIANT HEALTH, PLLC

MASSAGE, BODYWORK & SPA THERAPY TREATMENT FORM

NAME_____ DOB_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE (H)_____ (W)_____ (C)_____

E-MAIL:_____ OCCUPATION_____

REFERRED BY_____

REASON FOR VISIT_____

PLEASE STATE ANY PAST OR PRESENT INJURIES, ACCIDENTS OR MEDICAL TREATMENTS:_____

_____

_____

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS YOU HAVE CURRENTLY; CHECK ANY CONDITIONS YOU HAVE HAD IN THE PAST.

NECK/SPINE INJURY	HIGH BLOOD PRESSURE	LIVER AILMENT
BACK PAIN	LOW BLOOD PRESSURE	KIDNEY AILMENT
SCIATICA/LEG PAIN	SKIN DISORDERS	HEART AILMENT
CARPAL TUNNEL	INFECTIOUS DISEASE	FIBROMYALGIA
TMJ SYNDROME	DIABETES	CANCER
SPORTS INJURIES	ARTHRITIS	PMS SYNDROME
HEADACHE	COLD/FLU/FEVER	GRIEF PROCESS
VARICOSE VEINS	PREGNANCY	ALLERGIES
CHRONIC FATIGUE	SPINAL PROBLEMS	BLOOD CLOTS
INGREDIENT SENSITIVITY	OTHER_____	

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?_____

WHOM?_____

PLEASE LIST ANY MEDICATIONS TAKEN NOW OR AT REGULAR INTERVALS

_____

_____

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I AGREE TO UPDATE MY THERAPIST ON ANY CHANGES THAT OCCUR WITH MY HEALTH OR MEDICATIONS. I UNDERSTAND THAT NURSES AND MASSAGE THERAPISTS DO NOT DIAGNOSE DISEASE, PRESCRIBE MEDICATIONS OR MANIPULATE BONES. I FURTHER UNDERSTAND THAT THE THERAPY I RECEIVE TODAY IS NOT A SUBSTITUTE FOR MEDICAL ATTENTION OR EXAMINATION. ALL INFORMATION GIVEN HERE AND SHARED WITH THE THERAPIST DURING MY APPOINTMENT IS CONFIDENTIAL, AND WILL NOT BE RELEASED WITHOUT MY WRITTEN PERMISSION.

SIGNATURE_____ DATE_____

We ask our clients to pay at the end of each visit, unless other financial arrangements have already been made. The time of your appointment is reserved for you. Please give us ***24 hours notice*** *if you are unable to keep your appointment.* ***We reserve the right to charge in full for no shows and cancellations without 24 hour notice.***

RELEASE

INITIAL UNDERSTANDING FOR EACH STATEMENT:

_____I understand that the spa therapy or massage services which I receive are designed to be a health aid for the purpose of relaxation, stress reduction, and relief of muscular tension, and are in no way to take the place of a doctor's care when such care is indicated. If I experience any pain or discomfort during the session I will immediately inform the therapist so that the therapy may be adjusted to my level of comfort.

_____I also understand that information exchanged during the session is educational in nature, and is intended to help me become familiar and conscious of my own health status, is held in confidence and to be used/shared only with my written permission.

_____I understand that the therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session(s) given should be construed as such.

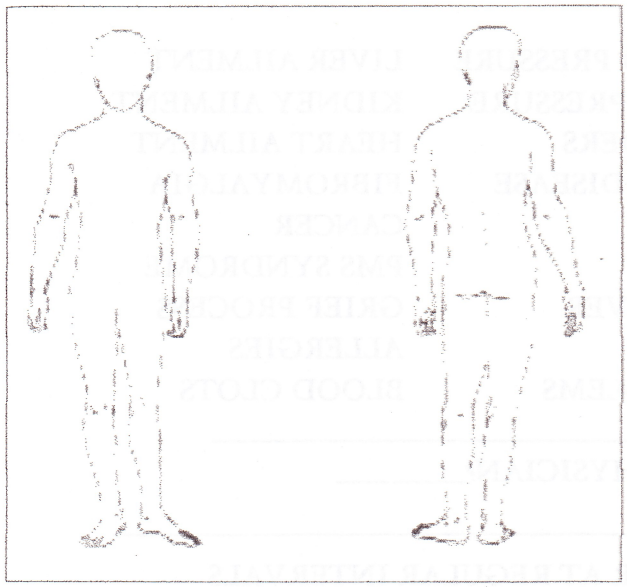
_____Because massage and some spa therapy treatments are contraindicated (should not be done) under certain medical conditions, I affirm that I will take the responsibility for keeping the therapist updated on all changes in my health status and medications, and that there is no liability on the part of the therapist should I not do so. In accordance with Texas law governing the transmission of infectious disease, I have stated all known medical conditions and answered all questions honestly.

_____I understand that the therapist shall not engage in breast massage of female clients without written permission (initial here _____ for consent) to do so.

_____I understand that proper draping procedures will be used at all times.

_____I understand that if I or the therapist becomes uncomfortable for any reason, either one may ask for the session to end immediately, and the session will end at that time.

_____ I also understand that any illicit or sexually suggestive remarks or advances made by me will result in the immediate end of the session, and **I will be liable for payment in full of the appointment.**



_____I have marked the areas I wish to have the therapist avoid with an "X".

_____I have marked the areas I wish the therapist to spend extra time/attention on with a circle.

No marks indicate no areas of concern.

I have reviewed all of the above client information and discussed areas of concern with the client.

_____

Therapist Signature

POLICIES

Please understand your time commitment begins at the moment you reserve a spa therapy or massage treatment. In order to make it fair for everyone, please consider your schedule carefully and don't commit to a time you feel may be questionable. There are times when a cancellation is, of course, necessary; but please give advanced notice whenever possible. Missed or canceled appointments (medical emergencies excluded) without twenty-four (24) hour notice **will be charged in full** for the missed session.

I have read and understand the above policy.

Signature_____Date_____