FREEBORN WELLNESS
COMPLETE INDUSTRIAL OT & PT

Therapeutic Massage

Personal Information

Name: ____

Date of Birth: _____/_____/_____ Age: ______ Height: _____ Weight: ______ Gender: ______________

Primary Phone #: ______________________ Alternate Phone #: ______________________

Preferred contact method: ☐ Call ☐ Text May we leave a detailed message? ☐ Call ☐ Text

Email: ____

Home Address: ____

Massage Information

Have you received professional massage before? ☐ Yes ☐ No

What type of massage are you seeking? ☐ Relaxation ☐ Therapeutic/Deep tissue ☐ Other: ______________

What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ____

Medical Information

Have you had any orthopedic injuries (List body part and approx. dates)? ______________________

____

____

Diagnostic Investigation:

X-Rays ☐ YES ☐ Current Injury; Results: ______________________

CT Scan ☐ YES ☐ Current Injury; Results: ______________________

MRI ☐ YES ☐ Current Injury; Results: ______________________

EMG/NCV ☐ YES ☐ Current Injury; Results: ______________________

Blood Test ☐ YES ☐ Current Injury; Results: ______________________

Myelogram ☐ YES ☐ Current Injury; Results: ______________________

Surgeries: ____

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Medications:

Prescription Medications: ☐ YES ☐ NO If YES, please specify: ______________________

Non-Prescription Medications: ☐ YES ☐ NO If YES, please specify: ______________________

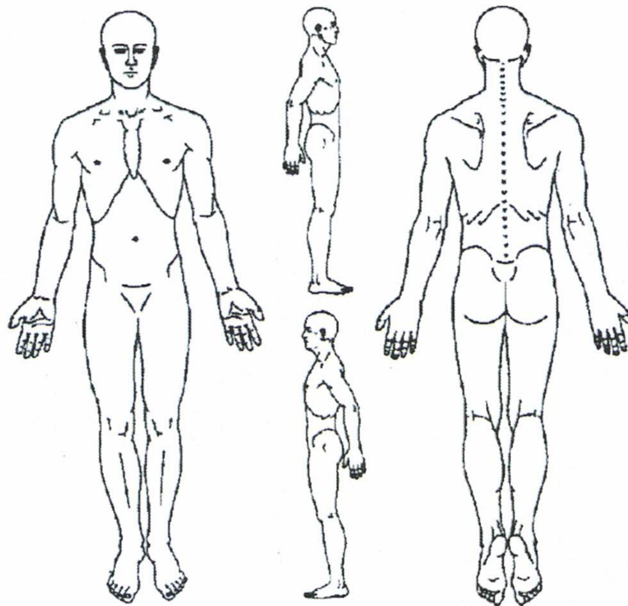
Medical Devices (prosthetics etc.) ☐ YES ☐ NO If YES, please specify: ______________________

Other Medical History: ____

Previous Treatments: *List approx. dates and any applicable comments.*

Physical Therapy ☐ YES; ______________________________
Occupational Therapy ☐ YES; ______________________________
Pain Program ☐ YES; ______________________________
Chiropractic ☐ YES; ______________________________
Psychological Therapy ☐ YES; ______________________________
Biofeedback ☐ YES; ______________________________
Massage Therapy ☐ YES; ______________________________
Acupuncture ☐ YES; ______________________________
Other ☐ YES; ______________________________

Shade your areas of discomfort. You may also indicate any additional symptoms like tingling or numbness.



Pain Ratings:

In the last two weeks what was your pain level 0/10?

What was your worst pain level? ___/10; Comments: ______________________________

What was your best pain level? ___/10; Comments: ______________________________

Current pain level? ___/10; Comments: ______________________________

Do you experience chronic pain?: ______________________________

Emergency Contact

Name: ______________________ Relationship: ________________ Phone: ______________

Massage Policies

Notice of Privacy Practices:
I acknowledge that I have been offered or have received a copy of the Freeborn Wellness's HIPPA and Privacy Policies.

Initial__________

Financial Responsibility:
The client is responsible for payment on the date of service, unless using insurance benefits. It is the client's responsibility to know what their insurance will or will not cover. By signing this disclaimer, I accept responsibility for payment of any and all expenses that are not covered by benefits of my insurance.

Initial__________

No Call/No Show/ Late Arrival Policy:
In an effort to provide effective and efficient treatment to all of our clients, it is the policy of Freeborn Wellness that all appointment cancellation is to be made at least 8 hours prior to the schedule appointment time.
If an appointment is not cancelled prior to 8 hours in advance and the client fails to attend their scheduled session, Freeborn Wellness reserves the right to charge the client of a $25.00 fee, per occurrence. If the client is more than 15 minutes late for an appointment, Freeborn Wellness reserves the right to shorten the client's standard appointment time as needed. In instances of late arrival 30 minutes or greater, the client may be asked to reschedule. Should a client be asked to reschedule due to late arrival of more than 30 minutes, the client will be charged a $25 rescheduling fee.

Initial__________

Three Strike Policy:
If your appointment is not kept due to a "no call/no show" or late developing situation - regardless of the reason, the missed appointment will be counted as a strike. After three strikes, Freeborn Wellness reserves the right to stop providing services to the client. The **latest** a cancellation call is considered acceptable is 8 hours prior to the date and time therapy is to take place. Freeborn Wellness implements this policy because it is in the best interest of the client to participate in services within the intervals set forth and due to the considerable difficulty for all parties to reschedule visits.

Initial__________

Infection Control Policy:
All individuals shall telephone to cancel and reschedule appointments when one or more symptoms of a contagious disease are present. This will aid in the protection of the health of the staff, and all others involved in the session/environment. Symptoms: Fever >100 degrees F, vomiting/nausea, open/draining lesion, lice, chicken pox, measles, productive cough, impetigo, conjunctivitis/pink eye, strep throat, diarrhea, any other contagious disease not listed.

Initial__________

Communication:
Freeborn Wellness uses various forms of electronic communication to stay in contact with our clients. Some of those include email, cell phone, and texting.

Initial__________

Therapy policies are known and acknowledged. I hereby consent to treatments by my massage therapist.

Client Signature: ____; Date: _____/_____/_____

Freeborn Wellness MT
No Show/Cancellation Policy

As a valued patient of Freeborn Wellness, we want to be able to provide effective and efficient treatment to all of our clients. It is the policy of Freeborn Wellness that **all appointment cancellations are to be made at least 24 hours prior to the scheduled appointment time.** Freeborn Wellness implements this policy because it is in the best interest of the client to participate in services within the intervals set forth, and the considerable difficulty for all parties to reschedule visits.

If an appointment is not canceled over 24 hours in advance and the client fails to attend their scheduled session, Freeborn Wellness reserves the right to charge the client a $50.00 fee, per occurrence. As this fee is not billable to any insurance company, the client accepts full responsibility to pay this late fee.

Notifying us of your schedule change with a minimum of 24 hours allows us to work around your schedule along with ours to provide treatments to other patients.

I, the undersigned, understand and agree to the above policy.

Print Name: ____ Date: ___/___/___

Signature: ____