MASSAGE THERAPY
CLIENT SUMMARY

rebound
Sports & Physical Therapy

PERSONAL INFORMATION

Legal Name _____ Nickname _____
First Middle Initial Last

Address _____

City _____ State _____ Zip _____

☐ Male ☐ Female Age _____ Date of Birth _____ SSN _____

Home Phone _____ Cell Phone _____

Email _____ Work Phone _____

Appointment Reminders ☐ Email ☐ Text ☐ Voice If text or voice, which number? _____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

Spouse Name _____ Phone Number _____

☐ Minor - Parent(s) Name(s) _____ Phone Number _____

Emergency Contact _____ Phone Number _____

Emergency Contact Relationship to Patient _____

MASSAGE HISTORY

Referred by _____

Have you ever had a massage? If yes, when was your last session? _____

Do you receive massage on a regular basis? _____

Please list anything in your past massage sessions that you've liked or disliked _____

_____

MEDICAL HISTORY

Primary Care Physician _____

Date of Injury _____ Date of Surgery _____

Please check the appropriate response.	YES	NO
Do you smoke?		
Do you exercise regularly?		
Is your current condition work accident related?		
Is your current condition auto accident related?		
Have you had physical, occupational, massage or chiropractic care for any reason this year?		

MEDICAL HISTORY CONTINUED…

Please check YES if you have ever (in your life) had, or do you presently have any of the following:

		YES
1	Anemia / Blood Disease	
2	Bone / Joint Problem	
3	Arthritis / Rheumatism	
4	Allergies	
5	Back Trouble/Hip Pain	
6	Breathing Problems (any kind)	
7	Broken Bones / Dislocation /	
8	Cancer or Tumor	

		YES
9	Diabetes	
10	Dizziness / Fainting	
11	Epilepsy	
12	Fibromyalgia Syndrome	
13	Headaches	
14	Head / Spinal / Neck Injury	
15	Heart Disease / Chest	
16	Hernia / Rupture	

		YES
17	High Blood Pressure or High Cholesterol	
18	Lung Disease	
19	Paralysis	
20	Pregnancy (Current)	
21	Skin Disease or Sores That Won't Heal	
22	Stroke	
23	Swelling of Feet or Joints	
24	Other	

If you have had any prior surgeries please give details below:

Surgery / Procedure	Date

I certify that I have reviewed and understand the above information supplied by me and that it is true and correct to the best of my knowledge. I hereby consent to such treatment which, in the judgment of my massage therapist, may be considered necessary or advisable while a client at Rebound Sports & Physical Therapy.

Client/Guardian Signature _____ **Date** _____

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CLIENT WELLNESS ATTENDANCE POLICY

In order to assure that all clients receive the time and attention they deserve, the following guidelines have been established:

1. If you are more than 15 minutes late for a scheduled appointment, without notification, you may not be able to be seen that day and you will be charged the full amount for the appointment.

2. If you need to cancel an appointment, please call 24 hours in advance to notify us. If your call is not during our normal business hours, please leave a message on our voice mail. There is a **$40 charge** for a cancellation without proper notice. This charge will be billed directly to you.

3. Your appointment time has been reserved for you. We have the right to assess the full charge amount for your appointment for the day if you miss a scheduled appointment without giving the required notice (no show). This charge will be billed directly to you.

I have read and understand this attendance policy.

Patient/Guardian Signature _____ **Date** _____

CONSENT TO DISCLOSE PATIENT INFORMATION / HIPAA

I understand this center's Notice of Privacy Practices and give permission for my protected health information to be disclosed for purposes of communicating results, findings, care decisions and appointments to the persons listed below:

Name _____

Name _____

Name _____

Name _____

Patient/Guardian Signature _____ **Date** _____

Patient Name (please print) _____