Energy in Motion Wellness **Client Information**

Name _____ Preferred Phone _____

Address _____ Date of Birth _____

City _____ State _____ Zip _____ Email _____

In case of emergency _____ Phone _____

How did you hear about this office? _____ Preferred form of communication _____

Massage Music Preference ☐ Classical ☐ New Age/Meditative ☐ Instrumental (piano/guitar) ☐ Other_____

General & Medical Information Age _____ ☐ Female ☐ Male Pronoun _____

Have you ever experienced a professional massage or bodywork session? ☐ Yes ☐ No How recently? _____

What type of pressure do you like? ☐ Light ☐ Medium ☐ Deep ☐ Unsure

If you answer "yes" to any of the following questions, please explain as clearly as possible where indicated below.

☐ Yes ☐ No Do you frequently suffer from stress?

☐ Yes ☐ No Do you have diabetes?

☐ Yes ☐ No Do you experience frequent headaches?

If so, where in your head? _____

☐ Yes ☐ No Are you pregnant?

☐ Yes ☐ No Do you suffer from joint swelling or arthritis?

If yes, where? _____

☐ Yes ☐ No Do you have high blood pressure, cardiac or circulatory problems?

☐ Yes ☐ No If yes to previous question, are you currently on medication?

☐ Yes ☐ No Do you suffer from epilepsy or seizures?

☐ Yes ☐ No Do you have varicose veins?

☐ Yes ☐ No Do you have osteoporosis

☐ Yes ☐ No Do you have any allergies?

If yes, please list here _____

☐ Yes ☐ No Do you bruise easily?

☐ Yes ☐ No Do you have any contagious disease?

☐ Yes ☐ No Have you ever had any broken bones?

List here _____

☐ Yes ☐ No Have you ever been in an accident or suffered any serious injuries?

☐ Yes ☐ No Have you ever had surgery? If yes, please list

_____

_____

☐ Yes ☐ No Do you suffer from back pain? Where in the back? _____

☐ Yes ☐ No Do you have numbness or stabbing pains?

Where? _____

☐ Yes ☐ No Are you sensitive to touch or pressure in any area? Where? _____

☐ Yes ☐ No Do you have any other medical condition I should be aware of?

_____

_____

_____

Are there any areas you DO NOT want me to work on? ☐ Yes ☐ No If so, where? _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

I understand that the massage/bodywork 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 may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork practitioners 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 given should be construed as such. **Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so.** It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature_____ Date_____

Practitioner Signature _____ Date_____

Consent to Treatment of Minor: With my signature below, I hereby authorize Leslie Cotham CMT, to administer massage, bodywork or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian_____ Date _____

Office Policies

Practitioner Name: Leslie Cotham, CMT
Contact Information: 805-235-6297
leslie@energy-in-motion.net

ENERGY IN MOTION
WELLNESS

Client Name: _____ Date: _____

Please be advised of the policies for this office. Your signature below signifies acceptance of these policies.

Cancellations
While I understand that cancellations are sometimes necessary, I ask that you please give at least 24 hours notice prior to canceling. This allows the opportunity for someone else to schedule an appointment. Any missed or canceled appointments within 24 hours will be charged the full amount. Should an illness or emergency arise, an exception to this policy will be made at my discretion.

Late Policy
In order to provide consistency and reliability in scheduling for all my clients, I ask that you please be on time for your appointment. Should you arrive late, it may be necessary to reduce your massage to the time remaining, as I now need more time after appointments to sanitize. If I do not have a client immediately following, I may extend your time at my discretion to a full session. If I am able to do that, I will check with you to see if that fits into your schedule before proceeding.

Sickness
Massage/bodywork is not appropriate care for infectious or contagious illness. Please cancel your appointment as soon as you are aware of an infectious or contagious condition. If it is within the 24-hour notice period, the cancellation fee will be waived.

Email List
Your signature below indicates that you give permission to be added to my email list. The email list is used to send out policy updates, annual specials and last minute appointment openings. You may opt-out at any time.

Financial Responsibility
Your signature below confirms your financial responsibility for all services.

Release of Medical Records
Your signature below authorizes the release of all of your medical records on file in this office, for the purpose of processing your claims, to the following: your attorney, the healthcare providers attending to this condition, and the insurance case managers. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through your attorney.

Signature _____ Date _____