Coulee Therapeutic Massage LLC

Heather Odenbach BS, LMT, CMLD

Please fill out all information as accurately and thoroughly as possible.

Date:_____

Name:_____ **DOB**: _____

Address:_____

Phone:_____

Email:_____

Emergency Contact:_____

Person responsible for payment:_____

Occupation:_____

Were you referred by anyone?_____

Check all medical conditions that apply to you

□ Arthritis □ Blood Clots □ Cancer □ Diabetes □ Epilepsy □ Fibromyalgia □ Headaches/Migraines	□ Heart Condition □ High/Low Blood Pressure □ Infections/Disease □ Joint Replacement □ Kidney Dysfunction □ Neuropathy □ Pregnant	□ Scoliosis □ Seizures □ Skin Disorders □ Stroke □ Surgeries □ Varicose Veins □ Other

Allergies:_____

Are you currently suffering from pain related to injury or trama? Y / N

Goals for bodywork/massage session (i.e. manage pain, relieve discomfort, maintain health, reduce stress, etc…)

_____

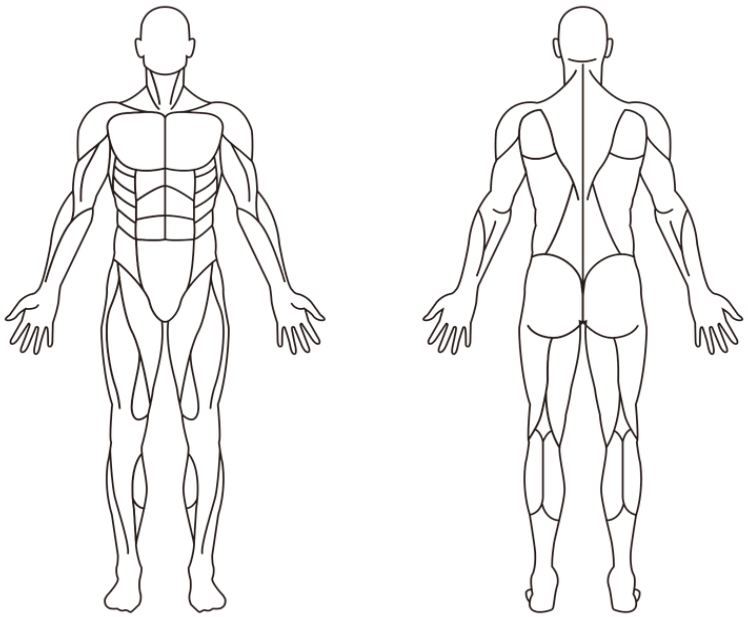
_____

_____

Client Discomfort Diagram

Please circle and label the area(s) of any pain or discomfort.

S = sharp D = dull A = achey T = tingly



Massage Therapy Consent

□ I understand that my practitioner is not a licensed MEDICAL healthcare provider and that massage is not a substitute for medical care, medical examination or diagnosis. I have stated all my known medical conditions and will inform my practitioner of any change in my health staus.

□ I understand that the practitioner does not diagnose illness, disease, or any other physical or mental disorder. The practitioner does not prescribe medical treatment or pharmaceuticals, nor does she perform any spinal manipulations. Any information provided by the practitioner is for educational purposes only and is not diagnostically prescriptive in nature.

□ I understand that the practitioner reserves the right to end the session in the case of sexual innuendo or advances from client.

□ I understand that payment is due at the time of service by cash, check or credit card. $2 will be added to all credit/debit card payments to offset the transaction fee.

□ I understand that if I arrive late to an appointment it is likely that I will not receive the full amount of time scheduled and I will still be responsible for full payment for the practitioner's time.

□ ***Cancellation Policy:***
We require 24 hours advanced notice for appointment cancellations, except in the case of an illness or emergency. Cancellations without 24 hour notice will result in a charge for half of the massage session time that has been reserved specifically for you.

Client Signature:_____ Date:_____

Parent/Guardian signature if under 18:_____ Date:_____