Alicia's
MASSOTHERAPY

APPOINTMENT & CANCELLATION POLICY

CREDIT CARD INFORMATION WILL BE REQUIRED TO SCHEDULE APPOINTMENTS.

CANCELLATIONS MADE WITH LESS THAN 24 HOURS NOTICE WILL BE CHARGED $50 FOR MASSAGE AND $25 FOR PILATES.

NO CALL/ NO SHOWS WILL BE CHARGED FOR THE FULL PRICE OF THEIR SCHEDULED APPOINTMENT.

Print Name: _____

Signature: _____ Date: _____

Alicia's Massotherapy / 16706 Chillicothe Rd. / Chagrin Falls, OH. 44023
440-543-2093

Confidential Client Information

Date	

General Contact Information	
First Name	
Last Name	
Middle Name	
Nickname	
Address	
City	
State	
Zip	
Cell Phone	
Home Phone	
Work Phone (ext)	
Birth Date	

Emergency Contact Information	
Name	
Relationship	
Phone	

✓ **How were you referred to us?**
By someone who is a client here / Name _____
By someone who is not a client here / Name _____
Signage
Website / Internet
Gift Card
Newspaper
Other _____

✓ **How would you like to receive appointment confirmations and reminders?**
Email
Text Message
Both email and text message

Based on your selections above, please provide us the necessary information:	
Email address	
Cell phone number to text	
Cell provider (Verizon, Sprint, etc.)	

✓	**What is your occupation? _____**
	Majority of time at a desk/computer
	Majority of time performing physical labor
	Majority of time driving
	Other, Explain_____

General and Medical Information
(If yes, please explain)

Yes	**No**	
___	___	**Are you currently under the care of any Health Care professional? _____**
___	___	**Are you wearing…(please circle) Contact lenses? Dentures? _____**
___	___	**Do you have any skin conditions or allergies?_____**
___	___	**Are you pregnant? If so, what stage? _____**
___	___	**Are you taking any medications (including ibuprofen/aspirin?)_____**
___	___	**Do you have varicose veins or blood clots? _____**
___	___	**Have you ever had any broken bones? _____**
___	___	**Do you have high or low blood pressure? _____**
___	___	**Do you have any heart condition? _____**
___	___	**Are you diabetic?_____**
___	___	**Do you have arthritis?_____**
___	___	**Do you have or have you had cancer?_____**
___	___	**Do you have spinal problems?_____**
___	___	**Do you have any infectious or contagious disease? _____**
___	___	**Have you recently suffered an injury? _____**
___	___	**Do you have any other medical condition I should be aware of? _____**

Previous History (Injuries, falls or surgeries)

Dates **Treatment**

----------PILATES APPOINTMENT----------

Have you ever experienced Pilates before? Yes / No

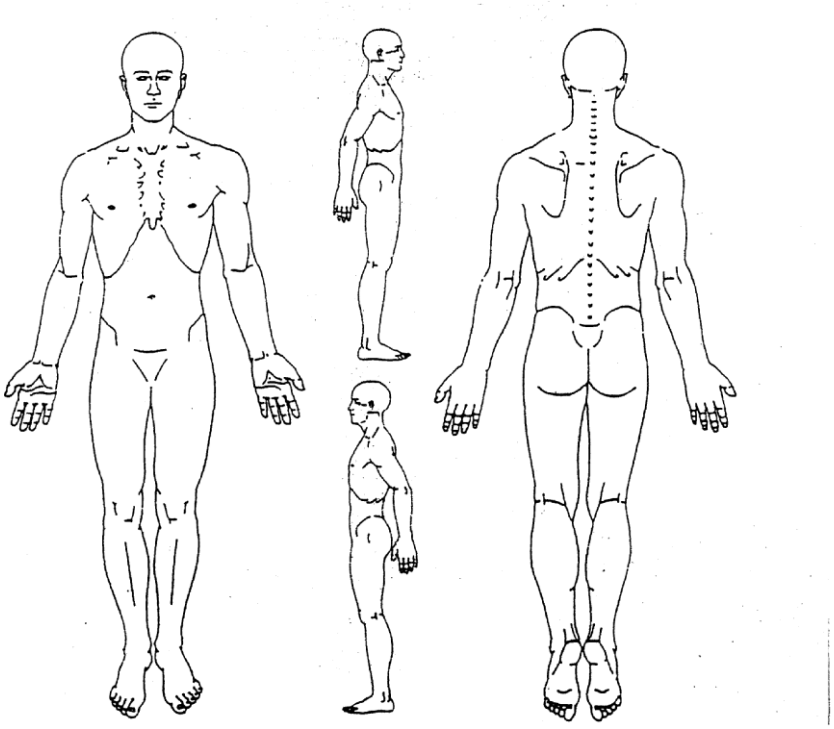
What do you hope to achieve with Pilates?

----------MASSAGE APPOINTMENT----------

Have you ever experienced a professional massage? Yes / No

What results would you like from your massage today?

Circle the areas you want us to focus on, X the areas you don't want us to touch:



PILATES APPOINTMENT

I state I am able to perform Pilates training and do not suffer from any condition that may prevent my fitness training or cause chronic injury. I have not had joint replacements, fusions or organ transplants. If I experience any pain or discomfort during a session, I will immediately inform the instructor. I further understand that the instructor does not diagnose illness, disease, or any other physical or mental disorder, nor does he/she prescribe medical treatment, pharmaceuticals, or perform spinal manipulation. I understand that I should see a physician, chiropractor or other qualified medical specialist for any known physical or mental ailments. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the instructor updated as to any changes in my medical profile.

I also understand that the Pilates sessions are my personal financial responsibility, and that I agree to pay for these services at the time of the session unless other arrangements have been made.

Client Signature_____ Date_____

MASSAGE APPOINTMENT

I understand that the therapeutic massage I receive here is for the basic purpose of stress reduction, relief of muscular tension, spasm, and/or pain. If I experience any pain or discomfort during a session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder, nor does she prescribe medical treatment, pharmaceuticals, or perform spinal manipulation. I understand that I should see a physician, chiropractor or other qualified medical specialist for any known physical or mental ailments. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile.

I also understand that the massage therapy sessions are my personal financial responsibility, and that I agree to pay for these services at the time of treatment unless other arrangements have been made.

Client Signature_____ Date_____