Treatment History

CONTACT HIGH MASSAGE, LLC

Form A

Contact High Massage, LLC is a coalition of independent massage therapists and bodyworkers. From time to time you may have a session with a different therapist than usual. Please take a moment to complete this form to help all our therapists be better acquainted with your needs. (How did you learn of us? _____)

This form should be updated once every year (preferably on the anniversary date of your first appointment).

Name _____ Cell # _____-_____-_____ Email _____

Address _____ City _____ State _____ Zip _____ Date of Birth _____/_____/_____

Tell us a little bit about you…

What brings you in today? If referral, who? _____

Tell us a bad massage experience: _____

_____

Tell us a good massage experience: _____

_____

Emergency Contact

Name _____

Cell Phone # _____-_____-_____

Work Phone # _____-_____-_____

Relationship _____

How are you today? On a scale from 0 – 10 (where 10 represents high pain or stress), please rate each of the following areas:

Head _____ Neck _____ Shoulders _____ Arms _____ Hands _____ Back _____ Hips _____ Upper Legs _____ Lower Legs _____ Feet _____

Now, please (**circle**) the areas above where you tend to hold your stress. Thank you! Are you under 18 years old? ☐Y ☐N

What do you suspect is the main culprit for stress in this/these areas? _____

What sort of pressure do you generally prefer? (Circle) all that apply. Light Medium Firm/Deep pressure Deep Tissue

Not everyone prefers therapeutic massage on the following areas. Please let us know your preference below. Are you OK (Y), or Not-OK (N) with these?

Scalp ☐Y ☐N **Face** ☐Y ☐N **Pectoral muscles** ☐Y ☐N **Abdomen** ☐Y ☐N **Gluts/Gluteal complex** ☐Y ☐N **Feet** ☐Y ☐N

Please bring us up to speed on your past and present physical concerns by placing a *Check Mark* or an *X* next to all items that *apply*, and explain below.

☐Allergies, including fragrances _____ ☐Arthritis, where? _____

☐Blood clots _____ ☐Blood pressure conditions _____

☐Cancer _____ ☐Chronic pain (joint, muscle, nerve) _____

☐Epilepsy _____ ☐Diabetes _____

☐Fibromyalgia _____ ☐Headaches, frequency? _____

☐Heat sensitivity/Hot flashes _____ ☐Heart conditions _____

☐Infections _____ ☐Injuries _____

☐Insomnia _____ ☐Immune System Deficiencies _____

☐Lupus _____ ☐Medications _____

☐Pain, Numbness, Tingling _____ ☐Pregnancy (must be booked with certified therapist) _____

☐Skin concerns (bruising, acne, rash, poison ivy) _____ ☐Surgeries _____

☐Varicose Veins _____ ☐Other _____

Greetings from Contact High Massage, LLC, a coalition of independent massage and bodywork therapists (herein referred to as "we" or "us" or "our"). As licensed professionals under the North Carolina Board of Massage and Bodywork Therapy (NCBMBT), our goal is to welcome all clients and staff into our professional offices, which are both safe and therapeutic. Contact High Massage, LLC, does not endorse all modalities and methods used by independent massage and bodywork therapists. If you have any concerns about your therapist or treatment, please bring it to our attention immediately. If at any time during the session you feel uncomfortable, please feel free and *empowered* to ask your therapist to end the session, or to make appropriate adjustments toward your comfort. Both male and female genitalia, and women's breasts will not be exposed or massaged at any time, and modest draping will be used during each session. It is a necessary part of our treatment strategy and your responsibility, for you to inform us of any pre-existing conditions, limitations (including limits to your range of motion), or specific sensitivities (including those of the skin, heat, and fragrances), and to inform your therapist if you feel any discomfort during treatment. You understand, acknowledge, and voluntarily accept the risk associated with massage and bodywork services and use of our facilities, and you hereby release us (including our affiliates, agents, assigns, and employees) from liability for any injury or claim (including, without limitation, personal bodily, or mental injury, property damage or economic loss), which may result from your treatment(s); your failure to disclose any pre-existing condition, limitation or sensitivity; or your failure to inform your therapist of discomfort during your session. We may, in our sole discretion, refuse or discontinue treatment services if we determine such services may be unsafe or cause discomfort for you. The undersigned acknowledges she/he has read and understands this disclaimer.

Signature _____ Date _____

Office Use Only: X = PAID _____ Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec / Year _____ Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

$10 Membership Info: Year _____ Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec / Year _____ Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

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