Harbor Health & Massage LLC
444 Washington Ave.
Holland, MI 49423

Client Information

Name_____ Date of Birth_____

Address_____ City_____ State _____ Zip_____

Day Phone _____ Evening Phone _____ Occupation _____

Emergency Contact Name_____ Emergency Phone _____

Would you like to be on our mailing list? ___ yes ___no If yes, email address_____
Have you ever had a professional massage? ___ yes ___no
How did you hear about us? _____

Many conditions can affect our massage treatment plan. Please check conditions you have or have had in the past:

Current	Past		Current	Past		Current	
_____	_____	bone/joint disease	_____	_____	sinus problems	_____	rashes/bruises
_____	_____	neck/shoulder/arm pain	_____	_____	stroke	_____	open cuts
_____	_____	low/mid back pain	_____	_____	broken/fractured bones	_____	cold/flu
_____	_____	hip/leg pain	_____	_____	diabetes	_____	fatigue
_____	_____	TMJ dysfunction/jaw pain	_____	_____	high blood pressure	_____	athlete's foot
_____	_____	whiplash	_____	_____	low blood pressure	_____	sunburn
_____	_____	tendonitis/bursitis	_____	_____	sleep disorders	_____	warts
_____	_____	headaches/head injuries	_____	_____	breathing difficulty		
_____	_____	numbness/tingling	_____	_____	varicose veins		
_____	_____	auto-immune disorder	_____	_____	epilepsy		
_____	_____	lymphedema	_____	_____	heart condition		
_____	_____	blood clots	_____	_____	nicotine addiction		
_____	_____	sciatica	_____	_____	caffeine addiction		
_____	_____	fibromyalgia	_____	_____	alcohol/drug addiction		
_____	_____	chronic pain	_____	_____	eating disorders		
_____	_____	herpes/shingles	_____	_____	skin condition:		
_____	_____	depression	_____	_____	cancer (type _____)		
_____	_____	constipation	_____	_____	vertigo/dizziness		
_____	_____	irritable bowel syndrome	_____	_____	other: _____		
_____	_____	limited range of motion			_____		

- Are you pregnant? _____ yes _____ no # of Months ____
  - If so, do you have a doctor's permission? _____ yes _____ no
- Are you currently taking any medications? _____ yes _____ no If yes, please list:
- Do you currently have any pain or discomfort? _____ yes _____ no If yes, where?
- Do you have any infectious diseases? _____ yes _____ no If yes, please list:
- Do you have any allergies? _____ yes _____ no If yes, please list:
- Have you had any surgeries? _____ yes _____ no If yes, please list:
- Have you taken any pain medication today? _____ yes _____ no If yes, please list:
- Do you have Post-Traumatic Stress Disorder? _____ yes _____ no
- Do you have a sensory processing disorder? _____ yes _____ no

-over-

Please read and sign below:

I have stated all known medical conditions on this form and answered all questions honestly. I understand that massage/bodywork may be contraindicated for certain conditions. I will update the massage therapist of changes in my medical profile, and understand there will be no liability to the massage therapist should I fail to do so. A referral from my primary care physician may be required prior to services being provided. If I experience any pain or discomfort, I will immediately notify the massage therapist. Massage/bodywork should not be construed as a substitute for medical examination, diagnosis or treatment. I understand that the massage therapist is 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(s) shall be construed as such. Any illicit or sexually suggestive remarks or advances will result in immediate termination of the session, and I will be liable for payment of the appointment. I understand that my records are protected under confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided in the regulations. I may revoke this consent at anytime except to the extent that action has been taken in reliance on it, and that, in any event, this consent expires upon my notification. I acknowledge that the information to be released was explained to me and consent is given of my own free will.

Initial_____

Cancellation Policy We appreciate your promptness, professional consideration and courtesy.

I understand that Harbor Health and Massage LLC(HHM) requires 24-hour notice to cancel my appointment without penalty. Should I miss an appointment without giving this notice, HHM has the right to bill me for the appointment. If I have a prepaid package, the cost will be deducted automatically. However, if I send someone to take my place, I will not be responsible for payment of the session unless s/he does not show. By signing below, I acknowledge that I have read and understand the cancellation policy.

Initial_____

As a Client, it is your responsibility to:

1. Communicate your preferences, expectations and concerns.
2. Communicate complete and accurate health information and reasons for your visit.
3. Treat staff and other guests with courtesy and respect.
4. Use products, equipment and therapies as directed.
5. Engage in efforts to preserve the peace and calm of a therapeutic environment.
6. Turn off cellphones and or other devices so we can focus on you during our time together.

As a Client, you have the right to:

1. A clean, safe and comfortable environment.
2. Stop a treatment at any time, for any reason.
3. Be treated with consideration, dignity and respect.
4. Confidential treatment of your disclosed health information.
5. Trained staff who respectfully conduct treatments according to treatment protocols and our policies and procedures.
6. Ask questions about your experience.
7. Information regarding staff training, licensing and certification.

Signature _____ Date _____