San Antonio Family Alternative Medicine

1931 N.W. Military Highway Suite #204 Castle Hills, TX 78213 Phone: (210) 340-2150

The World Health Organization defines Health as a "state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmary."

Expect Different.

Date:__________________ File:____________________

Last Name:______________________________ First Name:________________________ MI:_______

Date of Birth:____________________________ Age:___________ Gender: Male / Female

Street Address:____ Apt #:______________________

City:____ State___________ ZIP:_______

Cell Phone:__________________ Home Phone:______________ Work Phone:_________________

Fax Number:_________________ Email Address:__________________________ Newsletter? Y / N

Best way to contact (check all that apply): Work #_____ Cell #_____ Home #_____ Email____

Occupation:_____________________________ Stress Level from 1 (low), to 10 (high):__________

Emergency Contact:
Name:________________________________ Phone #: (____)______ Relation:______________

How were you referred to us?____

What brings you to see us today?____

How long have you been aware of this problem?______________________________________

What was the last straw that made you decide to address it **today**?____________________________

____

Have you had a professional massage before? (If so, was it for anything specific?)_________________

____

Please circle your level of exercise: Sedentary Infrequent Regular Athletic

Please circle your most frequent activities at work **and** at home:

Sitting/Computer Standing Lifting Walking Phone

Important: Please list **ALL** medications, prescribed AND/OR over-the-counter, including **dosage**.

______________________ ______________________ ______________________

______________________ ______________________ ______________________

(If you're taking more than 6 medications, please let us know and we'll provide you with more paper!)

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Please list all surgeries, accidents, broken bones, other hospitalizations, and/or other injuries, from the simple to the serious. Please be sure to also include childbirth, miscarriage, bike accidents, childhood falls, fender-benders, and organ surgery or removal (thyroid gland, gallbladder, kidney, intestine, appendix, etc), as well as wisdom tooth extraction.

Event:	Month & Year:
___	___
___	___
___	___
___	___
___	___
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___	___
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___	___

Do you have any known allergies, reactions, or sensitivities (skin, sinus, or other) to any particular nut/seed oils, aromatherapy scents/oils, laundry detergents, or incense?__________

____

Please review this list and circle any ailments that apply:

Diabetes	Heart condition	Ruptured/bulging/herniated disc
Arthritis (which type?_____)	Skin disorder (which?)______	Autoimmune disorder
Cancer (where?______)	Asthma	Fatigue
Stroke	Uncontrolled high blood pressure	Depression
Headache	Infectious/contagious disease*	Dizziness
Pacemaker	Artificial joints (which?_______)	Rods/pins (where?________)
Fibromyalgia	Pregnant (trimester________)	TMJ
Sciatica	Migraines	HIV/AIDS/Hepatitis C*
Scoliosis	Osteoporosis/osteopenia	Phlebitis/Deep Vein Thrombosis

Explanations, or other condition(s):____

*NOTE: For your protection and ours, please be truthful! These conditions don't always prevent you from receiving therapy. However, we NEED to know so that we can take preventive measures to avoid contracting/spreading the condition.

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Consent For Care: (please read carefully)

I understand that massage therapy is NOT a substitute for primary medical or chiropractic treatment and that I should consult a chiropractic physician, medical physician, or other qualified licensed specialist for any mental or physical ailment that I'm aware of.

I understand that massage therapy is not appropriate for all conditions, and that a referral from a primary healthcare provider (medical doctor or chiropractic doctor) and/or doctor at this clinic may be required prior to service being provided.

I will immediately inform my therapist of any unusual sensation or discomfort, so that the therapist may adjust his/her pressure or technique to my level of comfort.

Manual therapy will be given as agreed upon by therapist/clinic as client for the predetermined goals of relief of muscular discomfort, stress reduction, and/or to promote general health and wellbeing.

I agree to provide the therapist/clinic with complete and accurate information, and it is my responsibility as a client to update the therapist and clinic of any changes.

I understand that massage therapy is therapeutic only and is not in any way sexually-oriented, and that if I make any illicit or suggestive remarks or actions, the therapist may terminate the session immediately, with the full balance due.

I will always be properly covered by sheets/blankets or clothing.

A whole-body therapeutic massage typically includes the back, arms, legs, hands, feet, gluteal muscles (buttocks, never exposed), pectoral region (upper chest), neck, and scalp. Occasionally, treatment may necessitate the massage of the face, abdomen, or inside the mouth (always vinyl gloves). My therapist and I will discuss which areas will be worked and why, and I am always free to decline to work a particular area.

I understand that by signing this form, I give my consent to receive the treatment discussed here and in all sessions, and I agree that by scheduling future sessions, I'm further validating this consent.

I have read this form, answered questions honestly and completely to the best of my knowledge, and I give my permission to receive massage therapy.

Signature of Client:____Date:_______________________

Signature of Parent (if client is under 18):____

San Antonio Family Alternative Medicine ~ Elective Massage Therapy Cancellation Policy

What is Elective Massage Therapy?

Elective Massage Therapy is that which is not specifically prescribed by the chiropractic physician or Functional Medicine doctor at SA-FAM as part of a treatment plan. It typically consists of Integrative Massage, in which our licensed therapist skillfully combines multiple techniques to deliver a unique experience, for the purposes of wellness and stress management.

Who can schedule elective therapeutic massage visits?

Anyone!

Patients: Chiropractic and Functional Medicine patients may opt to schedule therapeutic massage visits in addition to their prescribed treatment plan.

Non-patients: Elective massage therapy clients need not currently be under our doctors' care in order to schedule with our therapist. We do require that non-patients seeking elective massage therapy schedule a brief screening/clearance first with one of our doctors prior to their first appointment.

What if I can't make my appointment?

We understand that Life Happens! However, please understand that our therapist is often highly sought-after, and we respect her and her time.

To cancel, reschedule, or shorten the duration of a scheduled appointment, we do require that you call us to let us know by the end of the previous workday, which in our office is 5:30pm, to avoid being responsible for the full amount of the scheduled visit.

To keep long-term costs low, we maintain credit card information on file to cover any appointment missed, cancelled/shortened on short notice, for guaranteeing business/corporate checks, or if you don't have your wallet with you; clients actually find this very convenient. All of your information is kept private, confidential, and secure, in a locked drawer.

The following information is required to receive elective massage therapy:

Visa/Mastercard/Discover

Expiration:

Home Phone:

Address (street number only):

Zip Code:

I have read, I understand, and I agree to the above information. In addition, I authorize the information I provided above to be used in my absence should I fail to show for a scheduled appointment.

Name as it appears on the card:____

First Middle Last

Patient/Client Name:____________________ Signature:________________________ Date:__________