Healing Sea Myofascial Release

Name_____Birth date_____
Address_____
City/State_____ Zip_____
Phone (cell)_____ (home)_____(other)_____
Email address_____
Occupation_____
How do you spend your time outside of work? (hobbies, sports, entertainment, etc): _____
How did you find out about Healing Sea? _____
What is your goal for today's session? _____
What are longer term goals? (What can't you do now that you would like to be able to do, or to be able to do better? Examples: to be able to lift my grandchild, to sit comfortably in a car for a three hour trip, to run a marathon….) _____
_____
Are you under the care of a physician or other health care practitioner? _____
If yes, for: _____
Please list medications and what they are used for (exact names less important than the ailments): _____
_____
Have you had any serious illnesses? _____ Please describe, including approximate dates: _____
_____
Have you had any surgeries? ___ Please describe, including approximate dates:
_____
Have you had any traumatic accidents or broken bones? Please describe, including approximate dates:_____
_____

Please check any that apply and give additional information/approximate dates below:

____high blood pressure	____insomnia	____circulatory condition
____heart attack/stroke	____low blood pressure	____osteoporosis
____low back pain	____osteomyelitis (bone infection)	
____open wounds/sutures	____hernia	____TMJ
____contagious conditions	____allergies	____fever
____skin infection	____aneurysm	____vertigo
____blood clots	____wire mesh (from surgery)	____cancer
____emotional trauma	____depression	____fibromyalgia
____serious injuries	____headaches/migraines	____arthritis
____edema (swelling)	____hematoma	____infection
____athlete's foot	____anticoagulant therapy	____diabetes
____plantar warts	____skin hypersensitivity	____sciatica
____other (describe below)		

_____
_____

I understand that the myofascial release massage services are designed to be a health aid and are not intended to take the place of a doctor's care when it is indicated. Information exchanged during any session is educational in nature, intended to help you become more familiar and conscious of your own health status, and to be used at your own discretion.

Signature_____ Date_____

CANCELLATION POLICY

When you make an appointment, I reserve time in my day just for you. Please respect our time together by giving at least 24 hours notice (more is always appreciated!) should you need to cancel or reschedule an appointment. Full payment is expected for sessions cancelled with less than a full 24 hours notice. Thank you for your understanding and consideration.

I have read the cancellation policy and agree to the terms.

Signature_____ Date _____