

Diva Nelson-Brown LMT  
Jessica Mason LMP

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First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female SSN: \_\_\_\_\_  
Name Suffix:  Jr.  Sr. (If applicable)

Address 1: \_\_\_\_\_ Address 2: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

Preferred Communication:  Phone  Mail/Letter  Email  Patient Portal  Fax  Decline  
Confidential Communications:  Home  Work  Mobile  Email  Patient Portal  Mail  Decline  
Personal Email: \_\_\_\_\_

**How would you like to receive appointment reminders?**

Text Message  Email  I choose to decline appointment reminders.

Have you ever experienced a professional massage or bodywork session? Yes  No

If yes, how recently? \_\_\_\_\_

**If you answer "yes" to any of the following questions, please explain as clearly as possible.**

- |   |  |
|---|--|
| Yes <input type="checkbox"/> No <input type="checkbox"/> Do you frequently suffer from stress?                              | Yes <input type="checkbox"/> No <input type="checkbox"/> Do you bruise easily?   |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have diabetes?  | Yes <input type="checkbox"/> No <input type="checkbox"/> Have you had any broken bones in the past two years?  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Do you experience frequent headaches??                             | Yes <input type="checkbox"/> No <input type="checkbox"/> Have you been in an accident or suffered any injuries in the last two years?                    |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Are you pregnant?  | Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have cardiac or circulatory problems?  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Do you suffer from arthritis?                                      | Yes <input type="checkbox"/> No <input type="checkbox"/> Do you suffer from back pain?   |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Are you wearing contact lenses?                                    | Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have numbness or stabbing pain anywhere?   |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Are you wearing dentures?  | Yes <input type="checkbox"/> No <input type="checkbox"/> Are you very sensitive to touch or pressure in any area?  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have high blood pressure?                                   | Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have any other medical conditions or are you taking any medications I should know about? |
| If "yes" to previous question, are you taking medication for this? Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> Have you ever had surgery? If yes, explain below  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Do you suffer from epilepsy or seizures?                           |  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Do you suffer from joint swelling?                                 |  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have varicose veins?  | Comments: _____  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have any contagious disease?                                | _____  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have osteoporosis?  | _____  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have allergies?   |  |

On the pictures below, use the key on the left to shade in the areas where you are currently experiencing discomfort:

**Key:**  
Numbness - - - - -

Pins and Needles ooooooooo

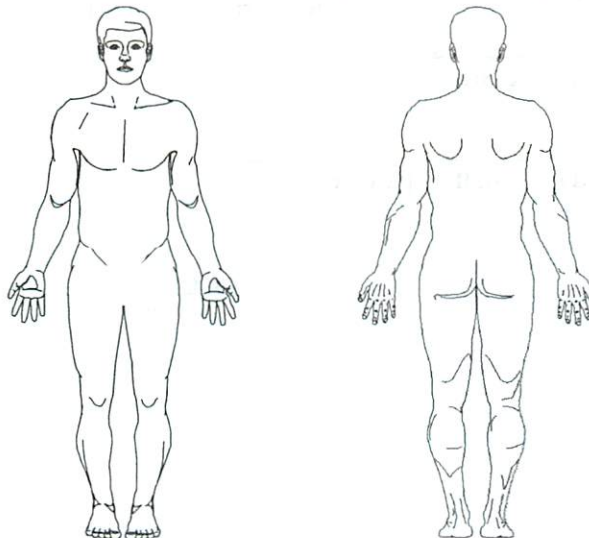
Burning xxxxxxxxx

Stabbing/Sharp ////////////////

Aching/Dull \*\*\*\*\*

Popping/Clicking P P P

Massage Referrals/Prescriptio



Massage Therapy is a common insurance benefit. This benefit must be referred by either your primary care or chiropractic provider. Having a referral does not guarantee coverage/payment from your insurance payer. Pre-authorization of Massage Therapy is required by specific insurance providers and plans. This is in addition to the prescription/referral. Pre-authorization approval of treatment does not guarantee payment from the insurance provider.

Initial: \_\_\_\_\_

**No Show/ Late Cancellation Policy**

As a courtesy, you are able to opt in for a text or email to confirm your service appointments. This will send you a reminder one business day prior to your appointment date. If you are unable to attend your massage appointment, we require that you verbally cancel your appointment with the receptionist the business day prior to your appointment time. In the event the patient does not attend or cancel the business day prior to their schedule appointment time, a fee of \$60.00 will be billed to the patient. This fee is NOT billed to your insurance payer; it is entirely the patient's responsibility. A credit or debit card on file is required to make any massage reservations. This card is charged when our cancellation policy is violated.

Initial: \_\_\_\_\_

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**Informed Consent**

I understand that the massage/body work I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or body work should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/body work practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that notion said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

\_\_\_\_\_  
Signature of the Patient

\_\_\_\_\_  
Date

**Consent to Treatment of a Minor:** By my signature below, I hereby authorize the massage practitioner to administer massage/body work or somatic therapy techniques to my child or dependent as they deem necessary.

\_\_\_\_\_  
Patient/Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name if signed on behalf of patient

\_\_\_\_\_  
Relationship

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**FOR OFFICE USE ONLY**

Massage Insurance Coverage? Yes No

Pre-Authorization Required: Yes No

Massage RX up-to-date? Yes No