Client Confidential Health Profile
Fulcher Therapeutic Massage LLC

Clients name: _____Home Phone: _____
Cell phone: _____ Text Y:___N:____Work phone: _____
Address: _____ City: _____ State: _____ Zip: _____
DOB: ___/____/____ Age: ____ M: ___ F: ___ Email:_____Y___N__
Employer: _____ Occupation: _____
Emergency contact: _____ Phone: _____
SS #:_____ Referred by: _____
Previously received professional Massage Therapy or Bodywork Treatment? Y: ___ N: ___
Primary healthcare provider: _____ Phone: _____

Personal Health History
Please check the conditions you are experiencing now or have in the past

O allergies	O chronic cough	O rash	O arthritis
O convulsions	O shortness of breathe	O sensitive skin	O epilepsy
O dizziness	O asthma	O eczema	O hemophilia
O fatigue	O emphysema	O bruise easily	O diabetes
O headaches	O heart disease/attack	O varicose veins	O internal pins/wires
O fibromyalgia	O high/low blood pressure	O psoriasis	O artificial joints
O TMJ	O stroke	O sinus	O degenerated discs
O ear problems	O vertigo	O cancer	

O allergies to oils/lotions/aromatherapy

Females: O pregnant; due date: _____ Males: O prostate cancer

Communicable diseases: O TB O hepatitis O HIV O shingles

Client Payment and Cancellation Agreement

I _____ declare that I am personally responsible for the payment of massage therapy at the time of service and also for missed appointments wherein I did not give 12-hour advance notice of cancellation.

We are committed to helping you reach your health and wellness goals. In order to do this, we ask that you adhere to our cancellation policy:

- After 1 late cancellation you will be given a verbal reminder and caution
- After 1 "no show" you will be assessed a $25 fee
- After 2 "no shows" or late cancellations you will be assessed a $25 fee
- After 3 "no shows" or late cancellations you will be assessed a $25 fee and will be required to prepay before making subsequent appointments

Failure to pay fees or comply with this agreement may result in refusal of treatment.

Signature: _____ Date: _____

Parent or Guardian signature of minor: _____

Please continue to the back

List all prescribed/over-the-counter medications and conditions treated:
Medications: _____ Reasons: _____
_____ _____
_____ _____
_____ _____
_____ _____

Surgical Procedures and dates:
_____
_____
_____

Please shade areas of pain: