Inner Balance THERAPY by Prema Lindsay Smith RN, CMT

Please print

Name _____ Date _____

Address _____ Referred by _____

_____ Gift certificate _____

Birth date _____

Preferred method?

Daytime phone number _____ ☐

Evening phone number _____ ☐

Email _____ ☐

Reason for visit:

_____

Please note current and previous injuries:

_____

Please note history of surgeries:

_____

Do you have any history of chronic pain?

_____

Are you taking medication or supplements?

_____

Are there any significant changes in your health status that your massage therapist should know?

_____

What type and frequency of exercise do you do?

_____

What is your occupation? _____

Name _____

Have you ever had a professional massage before? Yes ☐ No ☐

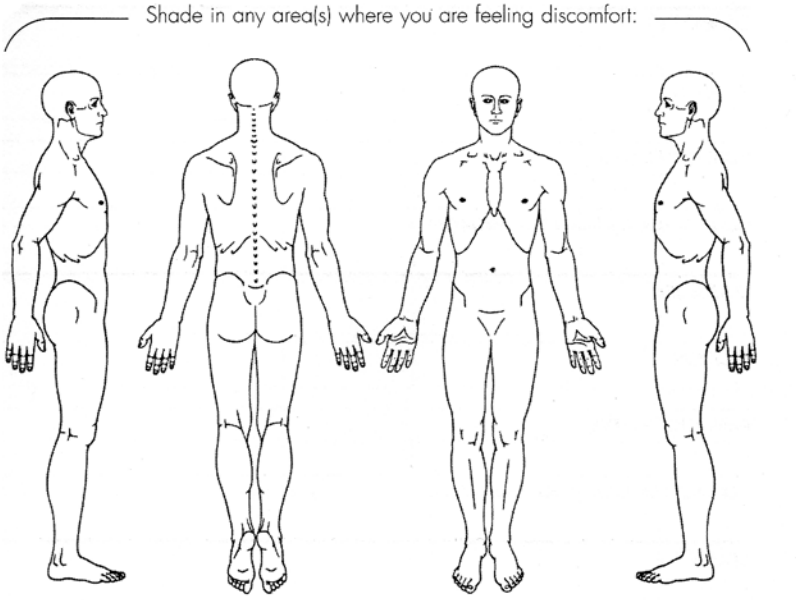
Are you right or left hand dominant? Right ☐ Left ☐

Do you wear contact lens? Yes ☐ No ☐

Do you have any allergies or aversions to the following?

Oils ☐ Lotion ☐ Laundry soap ☐ Therapeutic scents ☐

Please mark local pain with an "X". Shade areas or regions with non-specific pain or discomfort.



If you need to reschedule or cancel, please give a 48-hour advance notice during business days, Monday through Friday. Cancellations with less than a 24-hour notice will be charged a fee equal to 100% of the scheduled session charge; cancellations with less than a 48-hour notice will be charged 50% of the scheduled session charge. Thank you for your cooperation. Please provide your signature and date below to show that you have read our cancellation policy and agree to the terms and conditions. Please note that payment is required at the time of service.

Signed _____ Date _____

If you wish me to contact your health care provider, please provide pertinent information:

Name _____ Registration ID # _____|_____

Address _____

Phone number _____

I, _____, give Prema Lindsay Smith permission to consult with my health care provider.

Signed _____ on this date _____.