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| **NAME:** |  |  |  |  | **BIRTHDATE:** |  |  |  |
| **PHONE NUMBER:** |  |  |  |  | **OCCUPATION:** | |  |  |
| **ADDRESS:** |  |  |  | | | | | |
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| **EMAIL ADDRESS:** |  |  |  |  |  |  |  |  |
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| **EMERGENCY CONTACT:** |  |  |  |  |  |  |  |  |
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| **ANY INJURIES/SURGERIES :** |  |  |  |  |  |  |  |  |
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| **ANY MEDICATIONS:** |  |  |  |  |  |  |  |  |
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| **ANY ALLERGIES:** |  |  |  |  |  |  |  |  |
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| **ANY IMPLANTS:** |  |  |  |  |  |  |  |  |
| **(PINS, RODS, SCREWS)** |  |  |  |  |  |  |  |  |
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| **CANCELLATION POLICY: APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS OF THE START OF APPOINTMENT,WILL BE CHRGED THE FULL FEE OF THE APPOINTMENT, & IS DUE BEFORE ANOTHER APPOINTMENT CAN BE SCHEDULED. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | |
| **I UNDERSTAND THAT MASSAGE IS GIVEN FOR THE PURPOSES OF GENERAL HEALTH, WELLNESS, RELAXATION, IMPROVED CIRCULATION, PAIN MANAGEMENT, AND OTHER EFFETS SUPPOSTED BY THE EXPERIENCE AND RESEARCH. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | |
| **I UNDERSTAND THE THERAPIST DOES NOT DIAGNOSE MEDICAL CONDITIONS, PRESCRIBE MEDICAL TREATMENT, OR MEDICATIONS, NOR DO THEY PERFORM SPINAL MANIPULATIONS OR CHROPRACTIC ADJSUTMENTS. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | |
| **I UNDERSTAND THAT MASSAGE THERAPY IS NOT A SUSTITUTE FOR AN EXAMINATION BY A MEDICAL PROVIDER, AND THAT IT IS RECOMMENDED THAT I SEEK MEDICAL ATTENTION FIRST FOR ANY ILLNESS, INJURY, OR DISORDER THAT I HAVE. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | |
| **MASSAGE THERAPY CAN BE A VALUABLE COMPLEMENT TO WESTERN (AMERICAN) HEALTH CARE PROVIDERS AS WELL AS EASTERN (CHINESE) HEALTH CARE PROVIDERS. I AGREE TO KEEP MY MASSAGE THERAPIST INFORMED OF ANY MEDICAL TREATMENTS AND/OR MEDICATIONS I AM RECEIVING WITH THE UNDERSTANDING THAT IT MAY IMPACT THE MASSAGE THERAPY I RECEIVE. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | |
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| **SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | |  |
| **DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | |  |