

Therapeutic Massage & Nutritional Center
2456 N. Woodlawn Blvd, Ste 1A Wichita, KS 67220

NEW CLIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State _____ ZIP _____

Shipping Address: _____ Mobile Phone (____) ____ - _____

_____ Home Phone (____) ____ - _____

E-mail address: _____ Initial here to receive emails _____

REFERRED BY: _____

Occupation _____ Employer _____

Date of Birth _____ Age ____ Sex: M / F Height _____ Weight _____

Emergency Contact: _____ Emerg. Contact's Phone (____) ____ - _____

Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children, if any _____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Family history of serious illnesses (circle those which apply):

Cancer / Diabetes / Heart / Other _____

Please mark the conditions that apply to your **personal health history**:

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteopenia/Osteoporosis | <input type="checkbox"/> Carpal Tunnel Syndrome |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Thoracic Outlet Syndrome |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Fever (last 24 hours) |
| <input type="checkbox"/> Blood Clotting | <input type="checkbox"/> TMJ Dysfunction | <input type="checkbox"/> Communicable Disease |
| <input type="checkbox"/> Circulatory Disorders | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> HIV Virus |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Hospitalization |
| <input type="checkbox"/> Skin Condition | <input type="checkbox"/> Mild/Low Back Pain | Dates: _____ |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Injury |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hip & Knee Pain | Dates: _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Bulging Disc | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Diabetes | |

HISTORY:

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint (reason you are here): (use separate sheet if more room needed)

Previous treatments for this complaint _____

Other complaints or problems: (use separate sheet if needed) _____

Current medications/drugs being taken: (use separate sheet if needed) _____

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List any major illnesses (with approx. dates): _____

List any surgery or operations with approx. date: _____

Past Accidents or injuries: _____

Are you currently under the care of a physician or other health care professionals?

(If yes, please give name and date of last visit):

Name _____ Date _____

Nutritional supplements you are taking: _____

Allergies (drugs, food, other) _____

Do you smoke, drink coffee or alcohol? (If yes, indicate how much)

Cigarettes _____ Coffee _____ Alcohol _____

Do you have indoor animals? _____

Other information: _____

Client Signature

Date

OFFICE POLICIES:

_____ (initial) **Payment Policy:** I understand that all services are rendered on a cash, check, or credit card basis. Unless other arrangements have been made in advance, I agree to pay for each session at the time of the session. I also agree to the \$20 return check charge in the event that my check is returned.

_____ (initial) **Cancellation Policy:** I understand that any appointment NOT cancelled more than 24 hours prior to the scheduled time will be billed \$40. There will be one “grace” given for a missed or late-cancelled appointment.

_____ (initial) The information I have provided is truthful & complete to the best of my knowledge. I assume responsibility for advising the clinician of any changes in my condition. Should I experience pain or discomfort during massage, or adverse response to nutrition, I will immediately inform the practitioner.

_____ (initial) I understand that TMNC does **NOT diagnose or treat** medical disease/condition, nor prescribe; it is **NOT a substitute for physician diagnosis and treatment.**

_____ (Initial) We reserve the right to refuse service, as some health situations are beyond our care.

Appointment Reminders: Permission for a voicemail? Yes / No For a text? Yes / No

Client Signature: _____ **DATE** _____

Office Use Only: