

*Massages with Purpose*  
... Where Healing Begins



**Chad and Ginger Taylor LMT**

**(321) 480-9986 MA75423 / MA 93522 / MM35261**

**2070 Meadowlane Ave, W. Melbourne, FL 32904**

**PATIENT INFORMATION:**

**Today's Date:** \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

When was your last professional massage? \_\_\_\_\_ Do you consent to: Aromatherapy Y \_\_ N \_\_ / Hot Stones Y \_\_ N \_\_

What massage pressure do you prefer? \_\_\_\_\_ Referred By: \_\_\_\_\_

Please list your **GOALS FOR THIS SESSION** and areas of tension, stress and/or pain you wish to be addressed:

**Please indicate any of the following that apply to you:**

- |  |  |  |  |   |
|--|--|--|--|---|
| <input type="radio"/> Cancer             | <input type="radio"/> Headaches / Migraines    | <input type="radio"/> Arthritis                | <input type="radio"/> Joint Replacement(s) | <input type="radio"/> Neuropathy / Numbness |
| <input type="radio"/> HIV / AIDS         | <input type="radio"/> High/ Low Blood Pressure | <input type="radio"/> Neurological Disorders   | <input type="radio"/> Blood Clots          | <input type="radio"/> Hemophilia            |
| <input type="radio"/> Sprains/ Strains   | <input type="radio"/> Heart Attack             | <input type="radio"/> Kidney Dysfunction       | <input type="radio"/> Anxiety              | <input type="radio"/> PTSD                  |
| <input type="radio"/> Currently Pregnant | <input type="radio"/> Fibromyalgia             | <input type="radio"/> Bulging or Ruptured Disc | <input type="radio"/> Stroke               | <input type="radio"/> Infectious Disease    |

**Please list any medical conditions, surgeries, injuries, broken/dislocated bones, or scars**

- |           |           |
|-----------|-----------|
| (1) _____ | (4) _____ |
| (2) _____ | (5) _____ |
| (3) _____ | (6) _____ |

**Is there other information about you that your therapist needs to know prior to your session?**

**Your Appointment Time:**

This time is set aside for you. Out of respect and consideration to your therapist(s) and other customers, please plan accordingly and be on time. 24 hour Cancellation Policy, advance notice is required when cancelling an appointment. Massages with Purpose is unable to absorb the losses for missed appointments, no-shows, or appointments cancelled within a 24 hour period of the scheduled appointment. If you are unable to give the therapist 24 hour advanced notice, you will be charged a \$30 cancellation fee for your reserved appointment.

If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. If your therapist is able to contact the client after you to move their appointment to a later time, then your therapist will attempt to accommodate you at your full session. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for the Full session.

I understand that Sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated and will result in **immediate termination of the session**, and I will be **liable for full payment** of the scheduled appointment.

I understand that I am receiving massage therapy, microcurrent therapy, stretching, Lymphatic Drainage therapy, CranioSacral Therapy, and all other therapies that Massages with Purpose offers are at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy I hereby hold harmless and indemnify the therapist, Massages with Purpose, their principals, and agents from all claims and liability whatsoever.

I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I will inform my health care provider and massage therapist if anything changes in my status. I understand that massage/bodywork I receive is for the purpose of stress reduction and the relief from muscular tension, spasm or pain and to increase circulation, and is not a substitute for a medical examination or diagnosis and that I should see my health care provider for those services. If I experience any pain or discomfort, I will immediately inform my massage therapist so that the pressure and/or methods can be adjusted to my comfort level.

**CLIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_