Sister Rosalind Gefre Massage & Wellness Centers
Health Information Form

24-Hour Cancellation Policy:
All Cancellation and no shows will be billed at current rates if not notified within 24 hours of appointment.

How did you hear about Sister Rosalind Gefre Massage & Wellness Centers? (Check all that apply.)

☐**Friend/Family**_____ ☐**Internet** ☐**News Paper:**_____ ☐**Other:**_____

Would you like us to pray with/for you during your session? ☐ Yes ☐ No

Name: _____Date: _____

Date of Birth: _____Preferred Phone: _____Alternate Phone: _____

Address: _____ City/State: _____ Zip: _____

Email: _____ (Internal Contact Only)

Employer/Occupation: _____ Phone: _____

In case of emergency contact: _____ Phone: _____

Physician: _____ Clinic name: _____Phone: _____

CHECK ALL OF THE FOLLOWING THAT APPLY TO YOU

_____ Acne	_____ Fractures	_____ Kidney Disease
_____ AIDS (HIV)	_____ Glaucoma	_____ Lung Disease
_____ Allergies	_____ Heart Disease	_____ Neurological Disorders
_____ Arthritis	_____ Herpes	_____ Pregnancy (currently) Term: 1 2 3
_____ Athlete's Foot	_____ High Blood Pressure	_____ Rashes
_____ Cancer or Tumors	_____ Hives or Shingles	_____ Stroke
_____ Contact Lenses	_____ Impetigo	_____ Thyroid Disorders
_____ Diabetes	_____ Instrumentation	_____ Varicose Veins
_____ Eczema	_____ Joint/Back Problems	_____ Other

The physical condition that concerns you:

____ Fibromyalgia ____ Headaches ____ Carpal Tunnel ____ Chronic Pain

Are you taking medication or supplements presently? _____ Yes _____ No

If yes, please describe the medication/supplements: _____

Have you had a major surgical injury or procedure? Yes No_____

Is the injury related to work or auto accident? _____ Yes _____ No. Date of injury: _____

If yes, please describe: _____

Are you currently making routine visits to a physician, chiropractor, psychologist, or physical therapist for an ongoing problem? _____ Yes _____ No

If yes, please describe: _____

_____

Please circle the number which best describes your current level of stress:

(Low) 0 1 2 3 4 5 (High)

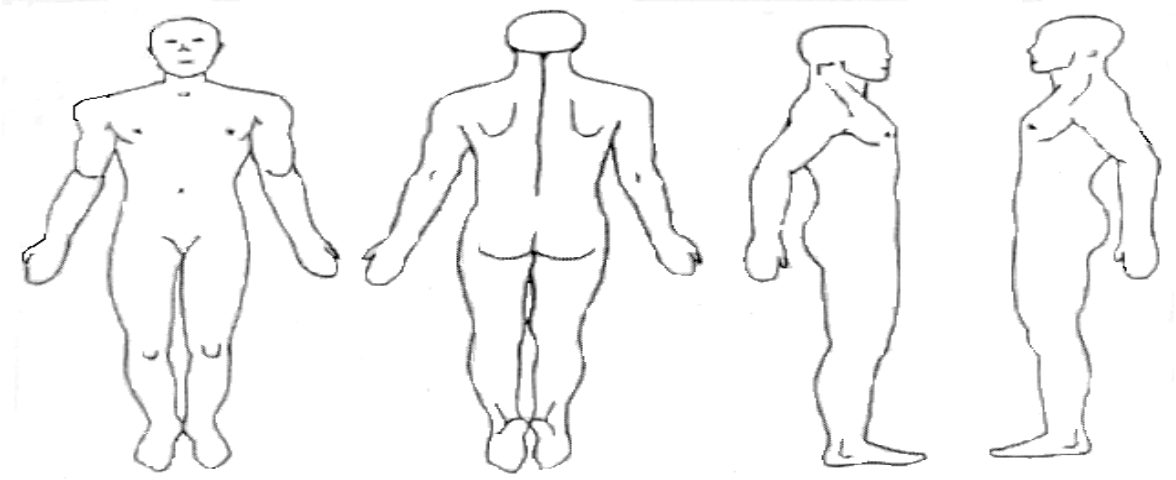
Please circle the number which best describes your current level of health:

(Poor) 0 1 2 3 4 5 (Excellent)

What types of exercise do you engage in regularly? _____

_____

If you are having problems in specific body areas, please mark them on the diagrams below.



Please indicate specific body areas with the following indications: N-numbness, T-tingling, ST-stiffness, S-soreness, P-pain, A-ache, Primary complaint?_____.

With these and other conditions that may exist, you and your physician acknowledge there are no medical reason that would prevent you from receiving massage treatment. Should your condition change, please notify your therapist before your next session, compassionate touch may be substituted.

I understand that chiropractic heath care services are offered at the massage clinics by a licensed Dr. of Chiropractic, but are no way practiced or prescribed by massage therapists including the practice of medicine. Client records and transactions with the practitioner are confidential.

I have received a copy of the complementary and Alternative Health Care Client Bill of Rights.

Payment is due upon completion of the service. Please make checks payable to Sister Rosalind Massage.

Signature: _____ Date: _____