

# Healing Arts Institute Massage Clinic

Please answer the following questions. The answers will better help us in providing service and will be kept completely confidential.

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Occupation: \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

How did you find out about us?

( ) Internet ( ) Word of mouth ( ) Facebook/Social Media ( ) Other-please specify \_\_\_\_\_

Do You Exercise? Y/N When was your last massage? \_\_\_\_\_

How much water do you drink per day? \_\_\_\_\_ Do you consider yourself stressed? Y/N

Describe any past surgeries, hospitalizations, accidents or injuries: \_\_\_\_\_

Are you currently experiencing any pain and/or movement restrictions? Y/N

Please describe: \_\_\_\_\_

What activities make the pain worse? \_\_\_\_\_

Please list all current medications: \_\_\_\_\_

WOMEN: Pregnant? Y/N Due Date \_\_\_\_\_

## Please check the appropriate boxes that apply to your present health

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Sinus problems          | <input type="checkbox"/> Sleep difficulties | <input type="checkbox"/> Headaches               |
| <input type="checkbox"/> Numbness/Tingling       | <input type="checkbox"/> Blood clots        | <input type="checkbox"/> Muscle or joint pain    |
| <input type="checkbox"/> Vision problems         | <input type="checkbox"/> Scoliosis          | <input type="checkbox"/> Shortness of breath     |
| <input type="checkbox"/> Jaw pain/teeth grinding | <input type="checkbox"/> Varicose veins     | <input type="checkbox"/> Diabetes                |
| <input type="checkbox"/> Infectious disease      | <input type="checkbox"/> Tendonitis         | <input type="checkbox"/> High/Low blood pressure |
| <input type="checkbox"/> Fatigue                 |   |  |
| <input type="checkbox"/> Depression              |   |  |
| <input type="checkbox"/> Other _____             |   |  |

I understand that if I receive a massage from a student an instructor will enter the room during the massage to observe and may demonstrate hands-on techniques on me. There is no observation in the professional clinic. I understand that I may be denied services at the HAI clinic if I behave inappropriately during the session or have consumed drugs or intoxicating substances prior to my appointment. I agree to comply with stated policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# **Healing Arts Institute**

## **Student & Professional Massage Clinics - Client Responsibilities**

### **During the session:**

- You will discuss with the therapist areas you need to have addressed during the massage (neck, back etc...)
- When the therapist leaves the room, undress to your level of comfort and lie down under the top sheet on the massage table.
- Your therapist will knock on the door before entering the room.
- Therapists have been trained in draping to insure your privacy and safety during the massage.
- If you are cold during the massage, ask the therapist to cover you with an additional blanket.
- **(student clinic)** A supervisor will knock & enter the room to observe for a few minutes and may demonstrate techniques.

### **When the session is over:**

- The therapist will leave the room to allow you to get dressed in privacy.
- **(student clinic)** Please fill out the feedback form after you exit the massage room. Tipping is not required. The purpose of the student clinic is educational. Your best tip is honest feedback.

### **In addition:**

- **(student clinic)** Should you have a preference for a male or female therapist, please inform the office at the time of scheduling. We will accommodate requests only upon availability. We encourage you to support both male and female therapists.
- **(professional clinic)** At time of scheduling you will be asked about preference for male or female therapist and will be scheduled & told the name of your therapist.
- If you are running late please inform us. Arriving late will reduce the length of your session.
- If you are uncomfortable with our policies, the therapist, or their technique, please request to see the student clinic supervisor or an administrator at the time of your visit.

We Reserve The Right To Refuse Service To Anyone For Any Reason

In particular, but not restricted to, consumption of intoxicating substances such as drugs or alcohol immediately prior to coming to the clinic, abusive behavior to any person at the clinic, sexual solicitation, inappropriate sexual innuendo or behavior, contagious disease, and unsatisfactory hygiene are understood to be reasons for denial of service.

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_