Patient Registration & Consent for Treatment

Name _____ Date of Birth _____

Phone # _____ Preferred Method of Contact: ❑ Phone ❑ Text Message, Carrier: _____

Address _____ City/State/Zip _____

E-mail _____ How did you hear about us? _____

Current Medications: _____

_____

Patient Medical History – Please check any conditions or treatments that apply to you

❑ Cancer ❑ Hypertension ❑ Diabetes ❑ Heart Disease ❑ Seizures ❑ Asthma ❑ Hepatitis ❑ Aneurysm ❑ Blood Thinners ❑ Bone fractures or acute soft tissue injuries ❑ cortisone/steroids ❑ fever ❑ hemophilia ❑ Hodgkin's disease ❑ infectious conditions ❑ inflammatory conditions (including arthritis, tendonitis, and bursitis) ❑ leukemia ❑ osteoporosis ❑ phlebitis ❑ recent scar tissue (including regular or plastic surgeries) ❑ I am pregnant (__ weeks) ❑ I carry an IUD ❑ Stroke ❑ Surgery: _____ ❑ Other significant medical issue: _____ ❑ I have an allergy to: _____

In the last 2 years, have you been involved in a motor vehicle accident? ❑ No ❑ Yes Date _____
Have you recently had any major fall or other injury? ❑ No ❑ Yes: _____
Do you currently have an attorney for either of these? ❑ No ❑ Yes

Massage therapists do not diagnose disease, prescribe medication or manipulate the spine. Please be advised that some deep massage work and Neuromuscular Therapy may cause soreness and sometimes even bruising. Please inform the therapist of any feeling of pain or discomfort **IMMEDIATELY**. I understand and agree that massage services, manual therapies, and structural integration provided by this licensed establishment are provided pursuant to and in accordance with the laws of the State of Florida and that full and complete medical history disclosure is essential in providing such therapy. I agree to hold harmless, release and indemnify this licensed establishment against any and all liability arising from the application of massage, manual therapy, or structural integration.

Our Payment Policy:

In an effort to minimize costs and create the best possible atmosphere for healing, we require payment at the time of service. Paying at the time of service frees this office from time-consuming paperwork and tracking of filed insurance claims. **This establishment is not in network with, nor do we accept assignment from, any health insurance provider**.

There will be a $25.00 Late Cancellation Charge in the event of a cancellation without prior notice of a minimum of 12-hours or a missed appointment with no notification to Balance Orlando.

I have fully read and understood the above.

_____

Client/Patient Signature **Date of Signature**

PLEASE COMPLETE BACK PAGE

What is your main reason for requesting treatment today?

_____

_____

How long have you been experiencing this?

_____

_____

What do you think caused it? _____

_____

Have you been given a diagnosis for this problem? If so, what?_____

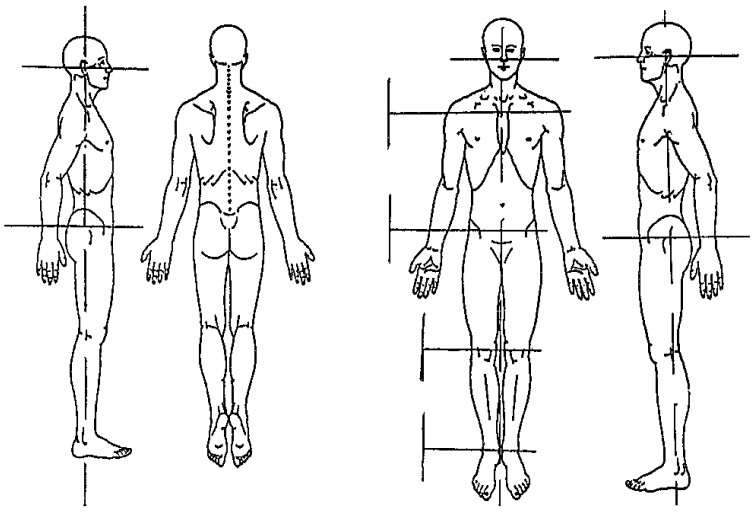
_____

What treatments have you tried already? _____

_____

What were the results? _____

_____



← **Please mark the diagrams to *note pain or problem* areas.**

How severe is your problem right now?
❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

What's the most severe level you have endured within the last week?
❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Additional Information:
Family Medical History

❑ High Blood Pressure	❑ Chemical Dependency	❑ Cancer	❑ Asthma	❑ Stroke
❑Heart Disease	❑Seizures	❑Arteriosclerosis	❑Diabetes	❑Allergies