Balance Orlando Patient Registration & Consent for Treatment

Name:_____Date of Birth:_____

Phone#:_____Email:_____

Address:_____City/State/Zip:_____

How did you hear about us? ❑Internet(Site Name):_____❑Flyer ❑Other (specific):_____

❑Another client (full name so we can thank them):_____

Current Medications:_____

Special Precautions:_____

Surgeries: ❑No ❑Yes (type & date(s))_____

_____

❑Allergies:_____

In the last two years, have you been in a motor vehicle accident? ❑No ❑Yes(Date):_____

Have you recently had a major fall or other injury? ❑No ❑Yes:

_____

Do you currently have an attorney for either of these? ❑No ❑Yes

Please check the box next to any conditions that apply to you:

❑Cancer ❑Hypertension ❑Diabetes ❑Heart Disease ❑Seizures ❑Asthma ❑Hepatitis ❑Aneurysm ❑Bone fractures or acute soft tissue injuries ❑Cortisone/steroids ❑Fever ❑Hemophilia ❑Hodgkin's Disease ❑Arthritis ❑Tendonitis ❑Bursitis ❑Leukemia ❑Osteoporosis ❑Phlebitis ❑Recent scar tissue (including regular or plastic surgeries) ❑Pregnancy ❑I carry an IUD ❑Stroke

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 assignments from, any health insurance provider.**

ALL SALES FINAL

All sales are non-refundable. We do not offer refunds on single sessions, packages, or unused membership credits. We guarantee our service, not the therapist. We strive to exceed service expectations. If you are not 100% happy with your service, let us know and we will find a way to make it right.

Cancellations within 24 hours of the scheduled appointment or not showing up for a scheduled appointment will result in a charge equal to 100% of the session price.

Client Signature:_____Date:_____

Please complete the back page ⟶

What is the 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 issue? ❒No ❒Yes:

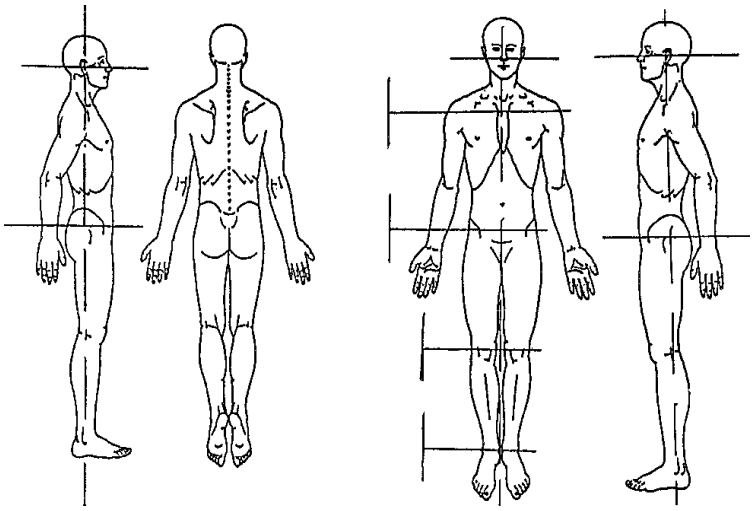
_____

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 ❒Heart Disease ❒Asthma

❒Stroke ❒Seizures ❒Arteriosclerosis ❒Diabetes ❒Allergies