Healing Happens
*Experience the Professional Difference*

# CONFIDENTIAL INFORMATION

Welcome. We want to make your appointment as pleasant and comfortable as possible.
If at any time you have questions regarding your visit, please let us know.

NAME: _____ H #: _____ W #: _____ C #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ AGE: _____ M F EMAIL ADDRESS: _____

OCCUPATION: _____ EMERGENCY CONTACT: _____

HOW DID YOU HEAR ABOUT US? _____

HAVE YOU EVER RECEIVED **MASSAGE THERAPY**? ☐ YES ☐ NO **RAINDROP** ☐ YES ☐ NO

ARE YOU TAKING MEDICATIONS? ☐ YES ☐ NO DESCRIBE: _____

_____

HAVE YOU CONSUMED ALCOHOL IN THE PAST 24 HOURS? ☐ YES ☐ NO

IS THERE ANY CHANCE YOU ARE PREGNANT? ☐ YES ☐ NO

## DO YOU HAVE A HISTORY OF THE FOLLOWING?

- ☐ abdominal pain
- ☐ accident
- ☐ allergic to oils or perfumes
- ☐ anxiety / depression
- ☐ arthritis, bursitis or gout
- ☐ breast augmentation
- ☐ broken bones
- ☐ bruise easily
- ☐ cancer
- ☐ chronic diarrhea or constipation
- ☐ chronic ongoing pain
- ☐ circulation problems
- ☐ colitis
- ☐ decreased range of motion
- ☐ diabetes
- ☐ disk problems
- ☐ fibromyalgia
- ☐ headaches
- ☐ heart attack
- ☐ Hepatitis A, B, or C
- ☐ high/low blood pressure
- ☐ HIV / AIDS
- ☐ IUD
- ☐ joint ache
- ☐ low back pain
- ☐ mid back pain
- ☐ multiple sclerosis
- ☐ neck pain
- ☐ nervous tension
- ☐ scoliosis
- ☐ seizures / epilepsy
- ☐ sprains
- ☐ stroke
- ☐ surgery
- ☐ transplanted organ(s)
- ☐ varicose veins
- ☐ wear contacts or other prosthesis
- ☐ whiplash
- ☐ other _____

## DO YOU HAVE ANY OF THE FOLLOWING TODAY:

☐ cold/flu ☐ inflammation ☐ open cuts, bruises, burns ☐ severe pain
☐ headache ☐ irritated skin-rash ☐ poison ivy/oak/sumac

ARE YOU CURRENTLY UNDER A DOCTOR(S) OR THERAPIST(S) CARE? ☐ YES ☐ NO

IF YES, BRIEFLY EXPLAIN: _____

_____

_____

## WHAT IS YOUR PRIMARY REASON FOR SEEKING MASSAGE THERAPY OR RAINDROP?

☐ general relaxation / stress reduction ☐ help with specific injury or condition ☐ pain relief ☐ other _____

## PLEASE READ THE FOLLOWING AND SIGN BELOW:

- ❖ I understand that this session is not a replacement for medical care and that no diagnosis will be made.
- ❖ I am responsible for paying for any appointment cancellation of less than 24 hours. INITIAL: _____
- ❖ Any sexual references or misconduct will end your session immediately.
- ❖ I understand that my records are confidential.
  Healing Happens abides by the HIPAA regulations.

**DATE: _____ SIGNATURE: _____**

**ID Checked _____ Source of ID _____**

**MUST HAVE 24 HOURS NOTICE FOR ANY CANCELLATION OF APPOINTMENT!**


PREMIER THERAPEUTIC SERVICES

*3701 Carlisle Road • Dover, PA 17315 • 717.292.4910*
*www.healinghappens.net*

Welcome, and thank you for choosing Healing Happens. Our goal is to provide you with the very best service.

**OUR PHILOSOPHY ON TIPPING**

Tips are always appreciated by our therapists, but are optional.

**REFERRAL SYSTEM**

Many of you have helped our practice grow by recommending Healing Happens to your family, friends, and co-workers. When you refer a client to us, we would like to say "thank you" with a $20.00 coupon, good towards your next visit.

On our health intake form, there is a place for the client to fill in how they heard about us. When we see your name, we will send you a card.

**CANCELLATION POLICY**

Your appointment time has been specifically reserved for you. A 24 hour notice is required for schedule changes or cancellations. The full fee of your session will be charged with less than 24 hour notice.

**RETURNED CHECK FEE - $35.00**

**INFORMED CONSENT AND RELEASE FROM LIABILITY:**

I understand that sessions are primarily for stress reduction and relaxation purposes. I acknowledge that treatments administrated to me are only for the purpose of helping me relax and to relieve stress. Therapists do not diagnose conditions, nor do they prescribe or perform medical treatment, nor interfere with the treatment I am receiving from a licensed medical professional. It is recommended that I see a licensed physician, or other licensed health care professional for any ailment I may have.

I also understand and believe that the body has the ability to heal itself, and to do so complete relaxation if often beneficial. Long term imbalances in the body sometimes require multiple treatments to allow the body to reach the level of relaxation necessary to bring it back into balance.

I confirm that I take full responsibility for alerting my therapist to any physical, mental or emotional conditions that could affect this work. I also take full responsibility to alert the practitioner of any discomfort or pain that happens during a session so that the practitioner can make any adjustments needed to assure my comfort and safety.

By signing this consent and release form, I hereby waive and release the therapist and Healing Happens, Inc., from any liability, past, present and future.

Please take a few minutes to read the above. Thank you again for the opportunity to serve you.

PLEASE SIGN_____ _____