Advanced Neuromuscular Therapeutics
Medical Massage Clinic
HEALTH HISTORY

NAME _____ DATE OF BIRTH: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
PHONE (H): _____ (W) _____ (C) _____
EMERGENCY CONTACT: _____(Phone)_____
Your Email Address: _____
If using insurance: Insurance Co: _____ ID# _____
If you are the spouse or child, Insured Name:_____DOB _____
EMPLOYER/OCCUPATION: _____
REFERRED BY: _____
SEX: _____ Male _____ Female

Have you had a professional massage before? _____ What type of pressure do you prefer? _____
Current issue or complaint, or any Muscular / Structural / Joint / Bone / Circulatory problems. Please circle and explain: _____
_____

Current or previous medical problems (please circle and explain) Surgeries, Fractures, Skin Problems, Blood Clots, Phlebitis, Varicose Veins, Blood Pressure, Heart Condition, Cancer, Communicable or Infections Diseases or other significant medical problems: _____
_____

On a scale from 1-10 (10 being high) how high is your stress level? _____
(work, family, relationships, car, money....etc)
How long has your stress been like this?_____
Tell me about your daily and weekly self care (circle) stretching, ice, heat, vitamins, ibuprophen
Weekly exercise Activities: _____
Weekly habits:

Alcohol _____ average per day	Caffeine _____ average drinks per day
Tobacco _____ average per day	Water Intake _____ average ounces per day
Sleep _____ average hrs/day	_____ Take Fish oil or Statin Drugs

I certify that the above information is complete and correct. I will keep you informed of any changes as they occur. I understand that Advanced Neuromuscular Therapeutics will not be liable for any injuries or loss sustained to myself or property while on the premises.

I understand that the time of my appointment is reserved for me. If, for some reason, I am unable to keep a future scheduled appointment, I agree to give you 24-hrs notice. I understand that emergencies do occur, however, in the event of a last minute cancellation or no-show appointment, I will be charged $40 for my missed appointment of 60 minutes or $60 for my missed appointment of 90 minutes. As a prerequisite, we ask that you provide an active credit card to guarantee payment of your bill. Your card will be charged for any missed or late cancelled appointment.
I agree to the above terms and authorize you to bill my credit card for a missed appointment or late cancel. Initials: _____

FYI-Our office offers insurance billing, Carolyn Durham is a provider for many health care plans and all motor vehicle med-pay and workers comp plans. Check with your plan and see if massage is covered.

Signature _____ Date _____

419 W Bijou St, Colorado Springs, CO 80905 Phone 719-229-9235 Fax 719-694-8170

For all clients we require a valid credit or debit card to be saved on your account. For new clients we require to have a card on file 48 business hours in advance of your appointment. In the event of a late cancellation or a no show your card on file will be charged $40 for a 60-minute massage or $60 for a 90-minute massage. By signing below, you agree to the terms and authorize Advanced NMT to bill your card on file for any missed appointment or late cancel.

You can provide your card information below or you can give you card information over the phone. If we do not have your card information 48 business hours in advance of your appointment, your appointment will be cancelled.

***If you gave your card information over the phone or in office please fill in client name, card holder name and sign.**

Gave Card information over the phone or in office: Yes____ No____ (If no, please fill out all fields below)
Client Name: _____
Card Holder Name: _____
Card #: _____ Exp Date: _____ CVV: _____
Card Holder Signature: _____