

THERAPEUTIC CONNECTIONS

massage & wellness

929 S. Main St., Ste. 104, Lombard, IL 60148

Welcome to Therapeutic Connections Massage & Wellness!

Please fill out and bring along these 3 forms to your appointment. To find our shared waiting room (next door to our suite) you will enter the building and go right at the "T", go down to the end of the hall and through the door in the center of the hall to take a seat, and your therapist will get you shortly.

When you schedule an appointment your commitment to that time begins. There are often times when we turn other appointments away because your scheduled time is held for you. We request all schedule changes or cancellations are given as soon as possible so that we have the opportunity to offer that time to other clients. ***Please note: Unless there is a medical emergency, without 24 hour minimum notice you will be required to pay for the missed appointment in full.*** As another option you may send someone in your place.

Your appointment begins at the pre-scheduled time arranged by you and your therapist, and may include a consultation and assessment during this time. To ensure that you receive the full amount of time booked, please arrive 5-10 minutes early.

In order to uphold our professional standards of being on time, we regret that we cannot give you any additional time if you arrive late. If for any reason we are late starting your appointment, you will receive the full scheduled amount of time.

Please arrive clean, showered and without any perfumes or scents to protect others who have allergies. We ask that you turn off your cell phone and refrain from using it until after you leave your appointment.

Thank you, we look forward to providing you with an exceptional experience!

*I have accurately disclosed all of my medical history to the best of my knowledge.

*I understand that massage therapists are not doctors and cannot diagnose any ailment or condition of any kind nor manipulate any bones.

*I take responsibility to alert my practitioner to any physical, mental, or emotional changes that occur with my health.

*Therapeutic Connections is not responsible for the aggravation of any conditions which were present but were not disclosed to the practitioner at the time of the massage.

Please provide 2 names and numbers of people who we may contact in case of emergency:

Contact #1: _____ relationship _____

Contact #2: _____ relationship _____

Signed: _____ Date: _____

(If under 18 guardian must sign.)

CONFIDENTIAL CLIENT INFORMATION

Name: _____ Date: _____

Address: _____ Apt: _____

City, State, Zip: _____

Telephone: (Daytime) (____) _____ - _____ (Evening) (____) _____ - _____

(Cell) (____) _____ - _____ (Email) _____

Occupation: _____ Employer: _____

Birthdate: ____/____/____ Age: _____ Referred By: _____

1. What is the primary reason for today's appointment? What are your expectations?

2. What has been your previous experience with Massage Therapy?

3. Have you had or do you presently have any of the following conditions or surgical procedures?
(circle applicable items)

- | | | | |
|-------------------------|----------------------|----------------------|------------------------|
| Arthritis | Asthma | Automobile Collision | Bursitis |
| Blood Clots | Bone Fractures | Cancer | Carpal Tunnel Syndrome |
| Cartilage Tears/Removal | Chronic Pain | Colitis | Colostomy |
| Coronary Bypass | Diabetes | Dizziness/Vertigo | Easy Bruising |
| Epilepsy | Epstein-Bar Syndrome | Fibromyalgia | Foot Surgery |
| Heart Problems | Headaches | Herniated Disk | Herpes |
| High Cholesterol | HIV/AIDS | Hemophilia | High Blood Pressure |
| Infectious Conditions | Joint Replacement | Kidney Ailment | Laminectomy |
| Ligament Tears | Lupus | Major Fall | Migraine Headaches |
| Multiple Sclerosis | Muscular Dystrophy | Neck/Spine Injury | Oral Surgery |
| Osteoporosis | Pregnancy | Sciatica | Scoliosis |
| Spinal Fusion | Tendonitis | TMJ | Tuberculosis |
| Tumors | Ulcer | Varicose Veins | Whiplash |

Explain:

4. In the past year, have you experienced emotional trauma? Yes No

Explain:

5. Miscellaneous (circle or answer applicable items):

Wear Contact Lenses Pacemaker Allergies: _____

Wear Dental Appliance Hearing Aid Wear Orthopedic Device in Shoe

Please indicate the types of medications you are currently taking: _____

Special Diet: _____

Physician: _____ Telephone: (____) ____ - _____

Do I have permission to contact your physician should the need arise? Yes No

Do I have permission to contact your other health practitioners should the need arise? Yes No

Frequency of your exercise: Never Occasionally Regularly

Please indicate the sports/exercise you participate in: _____

Do you perform stretching exercises: Never Occasionally Frequently

Major work activities: _____

6. Please circle, or indicate with an X, areas of pain or muscular tension that your are experiencing today on the chart below:

