Name:_____________________________________Referred by: ________________________________

Address____
Street City State Zip

Email___________________________________ May We Contact You via Email? ______Yes _____ No

DOB: ______________ Home Number ___________________ Cell Number______________________

Emergency Contact: ___________________Relationship:_____________ Phone:__________________

Occupation: ____________________________________ Date of last massage:____________________

Primary Health Care Provider: ___________________________________ Phone:________________________

Is this a Workers Compensation Claim or No-Fault Claim: _______Yes _____ No

If Yes: Date of Injury_________________________ Claim Number:______________________________

Insurance CO:_________________________ Adjuster Name & Number: __________________________

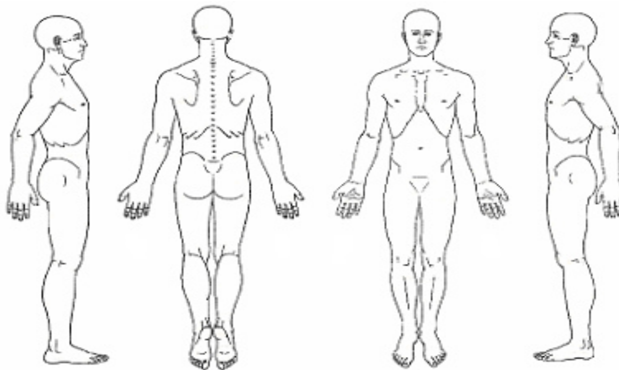
Are you presently taking any medication? ________ Yes ________ No

List Medications: ____

Have you had a recent major surgical procedure or injury? _______ Yes ________ No

Please explain:____

Please indicate with a circle or an X on the diagrams below any location that you have pain or discomfort.



Circle the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

Headaches
Joint stiffness/swelling
Spasms/cramps
Broken/Fractured bones
Strains/Sprains
Back, hip pain
Shoulder, neck, arm, hand pain
Leg, foot pain
Chest, ribs, abdominal pain
Problems walking
Jaw pain/TMJ
Tendonitis
Bursitis
Arthritis
Osteoporosis
Scoliosis
Other: ________________

Circulator/Respiratory

Dizziness
Shortness of breath
Fainting
Cold feet or hands
Cold sweats
Stroke
Heart condition
Allergies
To what: ______________
Asthma
High blood pressure

Digestive

Indigestion
Constipation
Intestinal gas/bloating
Diarrhea
Irritable bowel syndrome
Crohn's Disease
Colitis
Other: _____________

Nervous System

Numbness/tingling
Fatigue
Sleep disorders
Ulcers
Paralysis
Herpes/shingles
Cerebral Palsy
Epilepsy
Chronic Fatigue Syndrome
Multiple Sclerosis
Muscular Dystrophy
Parkinson's Disease
Other: ______________

Reproductive System

PMS_________________
Pregnancy
Other: ________________

Skin

Rashes
Allergies
Athlete's foot
Acne
Impetigo
Hemophilia
Other: _______________________

Other

Loss of Appetite
Depression
Difficulty concentrating
Hearing Impaired
Visually Impaired
Diabetes
Fibromyalgia
Post/Polio Syndrome
Cancer/Tumors
Tuberculosis
Drug/Alcohol addiction
Nicotine/Caffeine addiction
Eating Disorder
Other: ______________________

Infectious Disease

Name of disease______________

Low blood pressure

Assignment of Benefits

No Fault/Auto Accidents Claims (Only for car accidents claims)

I am responsible for all charges for all service provided. In the unfortunate event that my insurance company denies payment, or makes a partial payment, I am responsible for any balance due. I understand that my debit card on file will be deducted for any partial or denied payments from insurance.

I authorize and direct payment of medical benefits to Limahaʻi Massage Therapy for services.

____

Signature/ Parent or Legal Guardian if under 18. Date

Contract for care

I will participate fully as a member of my healthcare team. I will make sound choices regarding my sessions' plan based upon the information provided by my massage therapist. I agree to participate in my own self-care programs and adhere to the plan we select. I agree to communicate with my practitioner any time I feel my well-being is being compromised. I expect my practitioner to provide safe and effective treatment to the best of his or her skills and knowledge.

____

Signature/ Parent or Legal Guardian if under 18. Date

Cancellation Policy

Limaha‘i Massage Therapy understands unforeseen circumstances occur. As a courtesy, we will allow a one-time grace period of the cancellation policy without penalty. Further appointments will require a payment in full to hold future reservations.
I Understand statement above: **Initial** ______

I understand that if I fail to arrive for an appointment without 24-hr cancellation notice, that session is considered missed and I will pay an amount $75 for the missed appointment. I understand that any gift certificate and/or prepaid packages associated with my appointment will count as services rendered**.**
Understand statement above: **Initial** ______

I understand there is a 10-minute grace period. Sessions begin and end at scheduled times. I understand if I arrive late, I will lose that time off my session and will still be charged full price. If the massage therapist starts a session late, he/she will make it up to you at the end of session if possible or will reduce your fee accordingly.
Understand statement above: **Initial** ______

No-Show Policy

A no-show is when a patient misses an appointment without cancelling. Limaha‘i Massage Therapy will charge the client a $75 fee and require a Debit card to hold future appointments.
Understand statement above: **Initial** ______

For new patients' first appointments, a no show or late cancellation will result in a full fee charge of $75.
Understand statement above: **Initial** ______

When you book your appointment, you are holding a space on our calendar that is no longer available to our other clients. In order to be respectful of your fellow clients, please call our office as soon as you know you will not be able to make your appointment.

I have read and understand the above policies. (Please sign & date below)

____ Date__________________________
Client Signature

____ Date__________________________
Parent or Legal Guardian if under 18.

LIMAHAI
MASSAGE THERAPY

Cupping Therapy Client Release Form

- I understand that all treatments at this facility are therapeutic in nature. I agree to communicate to the therapist any physical discomfort or draping issues during the session.
- Information has been provided to me about Cupping Therapy. If I choose to experience these therapies during treatments, I understand the potential effects and after-care recommendations.
- It has been explained to me that there are contraindications for Cupping Therapy. I have fully disclosed all health factors to my therapist, including those not mentioned on my Health History Intake Form, to avoid any complications.
- It has been explained to me that there is the possibility of discolorations that can occur from the release and clearing of stagnation and toxins from my body.
- I also understand that this reaction is not bruising, but due to cellular debris, pathogenic factors and toxins being drawn to the surface to be clear away by my circulatory systems.
- I further understand that the discolorations will dissipate from a few hours to as long as 2 weeks in some. cases and in relation to my after-care activities.
- I understand that the first time I experience Cupping, my body's immune system can temporarily react to this release as it might with die flu -producing flu-like effects like nausea, headache, aches, that will subside in time with rest and water. Water helps to dilute the intensity of the release.
- I understand that Cupping Therapy modalities should not be combined with aggressive exfoliation, 4 hours after shaving, after sunburn or when I'm hungry or thirsty.
- I understand that I should avoid exposure to cold, wet, and/or windy weather conditions, hot showers, baths, saunas, hot tubs and aggressive exercise for 4 -6 hours. I understand that exposure to such extremes can produce undesirable effects and I should avoid such situations.
- I understand that I should avoid caffeine, alcohol, sugary foods and drinks, dairy and processed meat. and I should consume an abundance of clean water.

I, ______________________________ agree to allow the Cupping Practitioner to perform Cupping. I also agree that I have read, understand and will follow all of the information stated above and will not hold the practitioner responsible.

Client Signature: ____ Date: ________________________

Printed Name: ____

Date: ________________________

Practitioner Signature: ____

Printed Name: ____