LiMAHAi
MASSAGE THERAPY

One Kapiolani Plaza
600 Kapiolani BLVD STE 202
Honolulu, Hawaii, 96813
808-368-1898 | 808-744-9291 | www.limahaimassage.com

Name______________________________________Date_______________Referred by:___________________

Address____
Street City State Zip

Email____May We Contact You via Email?___Yes______No___

Date of Birth______________ Home Number ____________________ Cell Number______________________

Emergency Contact Name:________________________Relationship:_____________Phone:_______________

Occupation:______________________________________Date of last massage:___________________________

Primary Health Care Provider:____________________________________Phone:_________________________

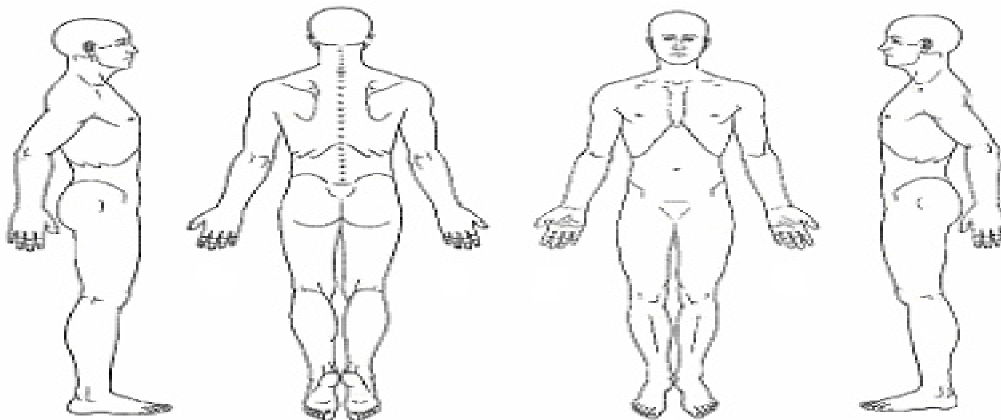
Are you presently taking any medication? __________Yes ____________No

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
Low 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
Hemophelia
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______________

____

Assignment of benefits

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 authorize and direct payment of medical benefits to Limahai Massage Therapy for services billed.

____

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.

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

____

Signature/ Parent or Legal Guardian if under 18.   date

Massage Cancellation Policy **Cancelling Your Appointment:**

Limahai 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 may require a payment in full to hold the reservation. **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 the full amount for the missed appointment. I understand that any gift certificate and/or prepaid packages associated with my appointment will count as services rendered**. Initial** _____

Your appointment may be rescheduled 24 hours prior to your appointment without penalty. **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 my session if possible, or will reduce your fee accordingly.
Initial_______

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

Client's signature____ Date___________________________
Parent or Legal Guardian if under 18.