

The Massage Center of Bellevue
37 103rd Avenue NE, Suite A
Bellevue, WA 98004
425-451-1171

Medical History

Name: _____ Date of Birth: _____

Email: _____ Referral Source: _____

Have you received massage therapy before? Yes / No What types? _____

Please list any medications you are currently taking:

Accidents, Injuries, or Surgeries in the past three years:

If you are currently experiencing any of the following, please indicate:

- | | | | |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High/low BP | <input type="checkbox"/> Pregnancy: Due Date _____ |
| <input type="checkbox"/> Athletes Foot | <input type="checkbox"/> Seizures | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Chemotherapy: Date _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood Clot | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Cortisone Injection: Date _____ |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Cold/Flu | <input type="checkbox"/> Inflammation | <input type="checkbox"/> Skin Disorders/Eczema |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Lupus | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Ailments | <input type="checkbox"/> Numbness | <input type="checkbox"/> Whiplash |

OTHER _____

I acknowledge that massage therapy is not a substitute for medical examination or diagnosis, and does not take the place of a physician's care when indicated. As massage therapy can be contraindicated with certain medical conditions, I affirm that I have stated all my known medical conditions, and will inform my practitioner of any changes in my health status. I understand that I am personally responsible for payment of the Massage Center of Bellevue's services, when these services are rendered, and for missed appointments without 24-hour advance notification. The staff reserves the right to refuse services at its discretion based upon the client's conditions, attitude or actions, without explanation or prior notice, and I agree to this policy. Questions regarding service procedures and recommendations are encouraged and welcomed.

Signature _____ Date _____

Cancellation & No-show Policy Agreement

As your appointment time is reserved specifically for you, the Massage Center of Bellevue has a cancellation/no show policy. Out of consideration for our therapists' time, we ask that you notify us 24 hours in advance should you need to cancel or reschedule your appointment. The Massage Center of Bellevue will charge a \$65 cancellation fee for missed appointments and late cancellations without 24 hour advanced notification.

We do appreciate that unanticipated events happen occasionally; emergency cancellations are handled on an individual basis.

As a courtesy, the Massage Center of Bellevue will make an effort to confirm with you the day before your appointment; however, it does remain the patients' ultimate responsibility to keep track of their appointments.

I have read and understand the Massage Center of Bellevue's cancellation policy, and agree to its terms.

Signature: _____ Date: _____

-No Tipping-
Please turn cell phones and pagers off while receiving your massage.