

Creative Wellness

8 Courthouse South Dennis Road
Cape May Court House, NJ 08210
Phone: 609-463-0999 ~ Fax: 609-778-1201

Internal Use Only: Ref T.Y.
 M.S.
 Eso. F Pat.
 E/W F Xmas

How you heard of us: _____

Client Information

Name: _____ Telephone: _____ Email: _____
Address: _____ Cell Phone: (____) _____
Date of Birth: _____
Age: _____
In Case of Emergency: _____ Telephone: _____

General & Medical Information

Occupation: _____ Male Female Physician: _____
 Yes No Have you ever experienced a professional massage or bodywork session? How recently? _____

If you answer "yes" to any of the following questions, please explain as clearly as possible.

<input type="checkbox"/> Yes <input type="checkbox"/> No Do you frequently experience stress?	<input type="checkbox"/> Yes <input type="checkbox"/> No Have you had any broken bones in the past 2 years?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No Have you been in an accident or suffered any injuries in the past two years?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience frequent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have tension or soreness in a specific area? Please specify: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have cardiac or circulatory problems?
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you diagnosed with arthritis?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have numbness or stabbing pains anywhere?
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No Are you sensitive to touch or pressure in any area?
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing dentures?	<input type="checkbox"/> Yes <input type="checkbox"/> No Any type of breast surgery?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No Prostate surgery?
<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" to previous question, are you taking medication for this?	<input type="checkbox"/> Yes <input type="checkbox"/> No Chemotherapy?
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you diagnosed with epilepsy or seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No Radiation?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have varicose veins?	<input type="checkbox"/> Yes <input type="checkbox"/> No Have you had one or more lymph nodes removed?
<input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any other medical conditions or taking other medication I should know about?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have osteoporosis?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have allergies?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you bruise easily?	

Comments: _____

I understand that the massage/bodywork and energy healing I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes or techniques may be adjusted to my level of comfort. I further understand that massage, bodywork and energy healing should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork and energy practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork and energy therapies should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

A cancellation after 3PM the day prior to your appointment time or not showing up for your appointment will result in you being charged the full appointment fee.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork, or energy therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____

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How would you like to feel after your experience with Kitty? _____

Which modalities which Kitty offers, eg. myofascial release, energy healing, etc. (see brochure) are you interested in or curious about? _____

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Privacy Practices Acknowledgement

Please take a moment to read "Privacy Practices" on wall in reception area. Thank you.

I have received/read the notice of Privacy Practices and have been provided an opportunity to review it.

Name: _____ Birth date: _____

Signature: _____

Date: _____

Please list below names of anyone you are allowing access to your medical records:
(Please note that your insurance company may ask for records when processing your claims.)
