Creative Wellness
211 Route 9 South #201
Cape May Court House, NJ 08210
Phone: 609-463-0999

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

How you heard of us: _____

Client Information

Email: _____

Name: _____ Telephone: _____ Cell Phone: (____) _____

Address: _____ 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.

☐ Yes ☐ No Do you frequently experience stress?
☐ Yes ☐ No Do you have diabetes?
☐ Yes ☐ No Do you experience frequent headaches?
☐ Yes ☐ No Are you pregnant?
☐ Yes ☐ No Are you diagnosed with arthritis?
☐ Yes ☐ No Are you wearing contact lenses?
☐ Yes ☐ No Are you wearing dentures?
☐ Yes ☐ No Do you have high blood pressure?
☐ Yes ☐ No If "yes" to previous question, are you taking medication for this?
☐ Yes ☐ No Are you diagnosed with epilepsy or seizures?
☐ Yes ☐ No Do you have varicose veins?
☐ Yes ☐ No Have you ever had surgery?
☐ Yes ☐ No Do you have osteoporosis?
☐ Yes ☐ No Do you have allergies?
☐ Yes ☐ No Do you bruise easily?

☐ Yes ☐ No Have you had any broken bones in the past 2 years?
☐ Yes ☐ No Have you been in an accident or suffered any injuries in the past two years?
☐ Yes ☐ No Do you have tension or soreness in a specific area?
Please specify: _____
☐ Yes ☐ No Do you have cardiac or circulatory problems?
☐ Yes ☐ No Do you have numbness or stabbing pains anywhere?
☐ Yes ☐ No Are you sensitive to touch or pressure in any area?
☐ Yes ☐ No Any type of breast surgery?
☐ Yes ☐ No Prostate surgery?
☐ Yes ☐ No Chemotherapy?
☐ Yes ☐ No Radiation?
☐ Yes ☐ No Have you had one or more lymph nodes removed?
☐ Yes ☐ No Do you have any other medical conditions or taking other medication I should know about?

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 12PM 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, e.g. myofascial release, energy healing, etc. (see brochure) are you interested in or curious about? _____

_____

_____

_____

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Privacy Practices Acknowledgement

Name:_____ Birth date:_____

Signature:_____

Date: _____

Please list below names of anyone you are allowing a discussion or written communication about your work with me at Creative Wellness.

_____

_____

_____

_____