Health Rhythms Medi Spa & Tan

4250 E. Florida Ave., Hemet, CA 92544

New Patient Information

Massage, Bodywork or Somatic Therapy Treatments

Name: _____ Birthdate: _____

Address: _____ City: _____ State: ____ Zip: _____

Phones: Home: _____ Cell: _____ E-Mail: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Widowed ○ Divorced # Children _____

Occupation: ○ Full ○ Part-time ○ Self ○ Student Employer: _____

Occupation: _____ Employer Phone: _____

General & Medical Information

Have you ever experienced a professional massage or bodywork session? ○**Yes** ○ **No** How recently? _____
Are you currently under the care of a chiropractor? ○**Yes** ○ **No**

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

○**Yes** ○ **No** Do you frequently suffer from stress?
○**Yes** ○ **No** Do you have diabetes?
○**Yes** ○ **No** Do you experience frequent headaches?
○**Yes** ○ **No** Do you wear contact lenses?
○**Yes** ○ **No** Do you suffer from arthritis?
○**Yes** ○ **No** Do you wear dentures?
○**Yes** ○ **No** Do you have high blood pressure?
○**Yes** ○ **No** If "Yes" are you taking medication?
○**Yes** ○ **No** Do you suffer back pain?
○**Yes** ○ **No** Do you suffer from epilepsy or seizures?
○**Yes** ○ **No** Do you suffer from joint swelling?
○**Yes** ○ **No** Do you have varicose veins?
○**Yes** ○ **No** Are you sensitive to touch or pressure?
○**Yes** ○ **No** Do you bruise easily?
○**Yes** ○ **No** Do you have any allergies?

○**Yes** ○ **No** Have you broken any bones in the last 2 yrs?
○**Yes** ○ **No** Have you been in an accident or suffered any injuries in the past 2 yrs.
○**Yes** ○ **No** Do you have tension or soreness in a specific area?
If Yes, Where? _____
_____
_____
○**Yes** ○ **No** Have you ever had surgery?
○**Yes** ○ **No** Have you had surgery within the last 5 yrs?
If Yes, Where? _____
_____
○**Yes** ○ **No** Do you have numbness or stabbing pains?
○**Yes** ○ **No** Do you have cardiac or circulatory problems?
○**Yes** ○ **No** Do you have osteoporosis?
○**Yes** ○ **No** Do you have a contagious disease?

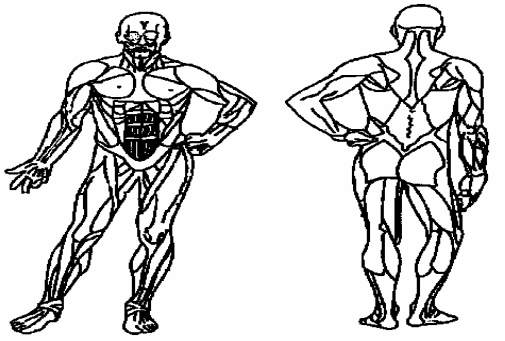
Do you have any drug allergies? ○**Yes** ○ **No** If yes, which? _____

Do you have any other medical condition or are you taking any medications I should know about? ○**Yes** ○ **No**

If yes, which? _____

Is your condition due to an accident? ○**Yes** ○ **No** **Illness?** ○**Yes** ○ **No** **Other?** _____
Did your accident occur at work? ○**Yes** ○ **No** Date of Accident: _____
Were you involved in an automobile accident? ○**Yes** ○ **No** Date of Accident: _____
Have you been treated before for this condition? ○**Yes** ○ **No** Did it help? ○**Yes** ○ **No**
What was done? _____

_____



NOTES

Patients Initials _____

Health Rhythms Medi Spa & Tan

4250 E. Florida Ave., Hemet, CA 92544

Are we billing your insurance? ○ Yes ○ No If 'yes' please answer the questions below.

Referring Physician:_____ Physician's Phone:_____

Employment: ○ Full ○ Part-time Occupation:_____

Employer: _____ Employer phone: _____ ext:_____

Employer's Address: _____ City:_____State:_____ Zip:_____

Spouse or Parent's Name:_____ Social Security # _____

Occupation:_____ Employer:_____

Employer's Address: _____ City:_____State:_____ Zip:_____

Person Responsible for payment on this account: _____

Insurance Information

Are you covered by Medicare? ○**Yes** ○ **No** Medicare # _____ Date of Last X-Ray:_____

Is your insurance coverage: ○ Group ○ Union ○ Personal Health ○ Auto ○ W/C Claim #: _____

Name of Insurance Company: _____ Group #: _____

Name of Insured:_____ Relation to Patient:_____ Policy #: _____

Address:_____ City: _____ State:_____ Zip:_____

Phone:_____

Additional Insurance Company:_____ Group #: _____

Name of Insured:_____ Relation to Patient:_____ Policy #: _____

Address:_____ City: _____ State:_____ Zip:_____

I understand my insurance will be billed as a courtesy. I agree all services rendered to me and I am personally responsible for payment whether my insurance pays or not. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patients Initials _____

Consent to Treatment:

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

I understand that the massage/bodywork 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 may be adjusted to my level of comfort. I further understand that massage or bodywork 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 practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork 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 accept that some massage/bodywork may cause bruising, skin irritation or burning and I will not hold the practitioners of or Health Rhythms Medi Spas liable. 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 practitioners 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 for the scheduled appointment. In the case of missed appointments we reserve the right to charge your account a fee of $5.00 if you do not call in advance.

Signature: _____ Client # _____ Date: _____

Print Name of Client: _____

Consent to Treatment of Minor:

I HEREBY GIVE MY PERMISSION as Parent [ ] Guardian [ ]

of _____ who is _____ years of age, to receive massage, bodywork or somatic therapy treatments from the professionals at Health Rhythms Medi Spa.

Signature: _____ Client # _____ Date: _____

Print Name of Parent/Guardian: _____

Miscellaneous Information:

Who may we thank for referring you to our office? Advertisement? ○ Yes ○ No Where? _____

Individual? ○**Yes** ○ **No** Name: _____