Confidential Patient Information

Coulee Health
920 WI-16 Suite A
West Salem, WI 54669

(608) 612-0777 Phone
(608) 807-5142 Fax
www.couleehealth.com

Name_____ Phone (day)_____ (evening)_____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: _____

_____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain _____

What makes it better? _____

_____

What makes it worse? _____

_____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: _____

Please indicate any of the following that apply to you.

☐ Cancer ☐ Headaches/Migraines ☐ Arthritis

☐ Diabetes ☐ Joint Replacement(s) ☐ High/Low Blood Pressure ☐ Neuropathy ☐ Fibromyalgia ☐ Stroke

☐ Heart Attack ☐ Kidney Dysfunction ☐ Blood Clots

☐ Numbness ☐Sprains or Strains

Explain any conditions you have marked:

_____

_____

_____

_____

Have you had a professional massage before? ☐ yes ☐ no

What type of massage are you seeking? ☐ Relaxation

☐ Therapeutic/Deep Tissue ☐ Other _____

What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain _____

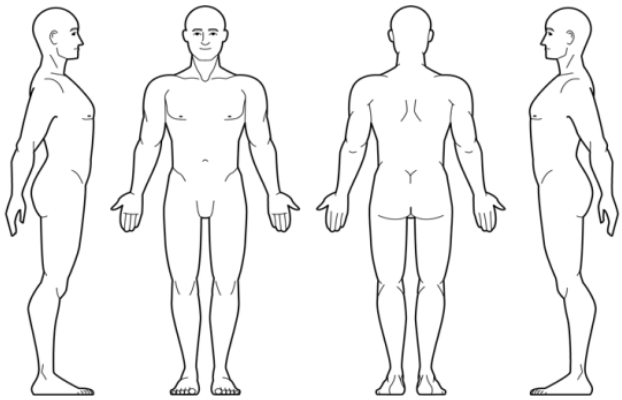
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



920 W Cty Hwy 16, Ste A

West Salem, WI 54669

(608) 612-0777

www.couleehealth.com

I, _____, have read and clearly understood the attached BUSINESS POLICIES/INFORMED CONSENT detailed by Coulee Health, and I would like to receive a massage therapy session (or request a session for my child or dependent). I understand that a copy of these policies is available to me at any time by request, and it is also located on the Coulee Health website. I understand the benefits and limitations of massage therapy as it may cause adverse reactions in certain situations. If I experience any discomfort during the session, I will immediately inform my therapist, so he or she can modify the massage technique. I understand massage therapists do not diagnose diseases or conditions, prescribe medications or treatments, or perform spinal adjustments. I recognize massage is not a substitute for medical treatment, and should I need medical treatment, I will seek out the appropriate health-care professional (physician, psychotherapist, chiropractor, etc.). I understand that it is my responsibility to keep the massage therapist informed of changes in my (or my child's/ dependent's) health status, diagnosed medical conditions, and medication. I understand that failure to inform the therapist of these changes may place me (or my child/dependent) at greater risk of adverse reactions from the massage. I release the massage therapist of any liability if I fail to disclose the appropriate health-related information. I understand that in order to book appointments at Coulee Health they must be scheduled online and prepaid at time of scheduling. **I understand Coulee Health charges a 50% fee for cancelling within 24 hours and will charge full price for sessions cancelled within 3 hours or no-call/no-show.** I understand that the intention of my massage is focused on therapeutic massage only. Any sexual advances, innuendo or inappropriate touch is expressly forbidden. *By signing below, you agree to the following. I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the information on the front changes at any time.*

Client's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

I authorize the therapists of Coulee Health to provide massage to my child or dependent:

Name of Child or Dependent: _____

Parent or Guardian Signature: _____ Date: _____