Elite Care
PHYSICAL THERAPY

Restorative Massage

Client Intake Form

RETURNING MASSAGE CLIENT Y / N

Name: _____ Gender: M / F / Other DOB: _____

Address: _____

Cell#_____ Alt#_____ Home / Work

Email for appointment reminders: _____

Are you a current patient being treated at Elite Care? Y / N

What is your goal in seeking therapeutic massage? Is there a specific area that were focusing on? _____

_____

What pressure or style do you prefer? (Circle all that apply) Soft tissue / Deep tissue / Trigger point/ Practitioner choice

Are there any specific areas that you do not want massaged? (Feet, face, abdomen, etc.) _____

_____

Are you ok with the practitioner incorporating in Myofascial Release or Craniosacral Therapy? Y / N

Have you had a professional Massage before? Y / N Date of last massage: _____

Is there any position that you are unable to lay in or is uncomfortable? Y / N _____

Who referred you/ how did you hear about us? Friend / Physician / Social Media / Other: _____

Emergency Contact Name: _____

Relationship: _____ Emergency Contact# _____

How would you rate your general health? (Circle one) Great / Mostly Good / Could Be Better / Not Good

Do you exercise regularly and if so what type? Y / N _____

Are you currently working (if so what's your job title) or retired? _____

What is your daily physical work/activity level? (Circle all that apply) Mostly sitting / standing **OR** Light / Heavy Labor

---

I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify Elite Care Physical Therapy of any changes in my status or above information.

PATIENT SIGNATURE: _____ **DATE**: _____

Restorative Massage

Health History

Please check the PAST or NOW for the following conditions, lift specifics if necessary:

Cardiovascular	PAST	NOW	Autoimmune Disease	PAST	NOW
Abnormal Blood Pressure			Fibromyalgia		
Heart Attack / Failure			Lupus		
Heart Arrythmias			Thyroid		
Cardiac Surgery			IBS		
Varicose veins			Ehlers-Danols		
Pacemaker			Multiple Sclerosis		
Blood Clot			Other: _____		
Other: _____			Other Conditions		
Respiratory			STD/HIV/Hep		
Asthma			Anxiety / Depression		
Lung Disease			Rash		
Recent Illness			Lyme Disease		
Sinusitis			Stroke		
Other: _____			Digestive Issues		
Musculoskeletal			Headaches/Migraines		
Dislocations Where: _____			Pregnant C-sections: _____		
Scoliosis			Bowel/Bladder Issues		
Arthritis			Loss of Balance/Falling		
Metal Implants Where: _____			Cancer Where: _____		
Fractures Where: _____			TMJ Disorder/ Jaw Pain		
Bursitis Where: _____			Vision Changes		
Osteoporosis			Hearing Changes		
Tendonitis Where: _____			Other:		
Other:					

Have you ever been in a car accident? Y / N _____

Have you had any prior major surgeries? Y / N _____

Have you ever had a major accident or injury at work or home that resulted in injury? Y / N _____

Do you have any specific allergies or hypersensitivities? Y / N _____

Are you taking any medications that cause easy bruising or make you hypersensitive to touch? Y / N_____

SIGNATURE: _____ **DATE**: _____

Elite Care
PHYSICAL THERAPY

Restorative Massage

Client Waiver

I,_____, (Please print full name) understand that the massage treatment(s) that I receive is/are provided for the purpose of relaxation, relief of stress, muscular tension, pain, and to aid the body with its natural healing process. By signing this waiver, I acknowledge that I attend this session at my own risk and will not hold Elite Care Physical Therapy or the practitioner liable for any accident, incident or injury that occurred within their scope of practice. **INITIAL**_____

I understand that a massage therapist works soft tissues and may integrate gentle range of motion exercises to the joints but will not administer spinal manipulations on purpose. A massage therapist may also use handheld instruments or tools to better assist in the manipulation of your tissues. Your therapist will ask your permission prior to your treatment starting, you as the client can refuse at any time before or during your treatment for the massage to end or tools not be used. **INITIAL**_____

If I experience any pain or discomfort during the treatment, I will immediately inform the therapist so that she can adjust her techniques and pressure to within my level of comfort. I am also informed that I have the right to stop massage treatment at any time. I am also aware that on rare occasion massage therapy may cause delayed onset muscle soreness. If it should happen it should go away within 24-48 hours. **INITIAL**_____

I have been informed that the massage therapist must meet standards and principals enforced by the Massage Therapy Act & Regulated Health Professionals Act and may at any time refer a client elsewhere if she feels that her client would benefit from alternatives to massage therapy or have greater potential of succeeding health wise with an alternative practitioner. I understand that massage is not a substitute for medical examinations or diagnosis and so I should seek a physician or other health professional should the need arise. I further understand that any sexual remarks or advances will immediately terminate the session and I will be liable for payment of the scheduled treatment without refund. I understand the Massage Therapist practitioner reserves the right to refuse services to me for any reason that she deems necessary for the safety of the practitioner and client. **INITIAL**_____

I agree that all the information that I have provided in my health history form is accurate. I acknowledge that to ensure appropriate treatment it is of upmost importance to inform my massage therapist of any old, current, or new injuries as well as inform them of any changes in my health status, or and concerns I may have now or at any future appointments. **INITIAL**_____

Restorative Massage

Missed Appointment Policy

If the need arises to cancel your session you **MUST** call within business hours the prior day to your appointment to get a full refund or reschedule your session. Failure to cancel the prior day before your session or no showing for an appointment will result in a **fee of $50**.**INITIAL**_____

I have been informed that a late arrival to my scheduled session for massage therapy may result in a shortened treatment, this time **will not be refunded** or rescheduled without additional costs on behalf of the client and depending on the therapist discretion. **INITIAL**_____

Out of respect and consideration for your therapist and other customers, please plan accordingly and be on time

SIGNATURE: _____ **DATE:** _____

Practitioner's SIGNATURE: _____DATE: _____

Elite Care
PHYSICAL THERAPY

Restorative Massage

by Valerie Downs, PTA, LMT, GTS, CKP

Provided bellow is a comprehensive list of Restorative Massage provided by Elite Care Physical Therapy with descriptions and charges:

- **Area Specific 30-minute Massage**
  Soft tissue, deep tissue, trigger point, sports,
  pregnancy massage with/ without tools $60

  - Package of 3 30-minute massage $170
  - Package of 6 30-minute massage $330

- **Area Specific 60-minute Massage**
  More time for treating soft and deep tissue techniques $95

  - **Myofascial Massage** - this massage is lotion and tool free, a specialized work of collagen connective tissue that encases our muscles and organs.

  - **Craniosacral Massage** - focuses treatment on the joints of the skull and fluid movement.

    - Package of 3 60-minute massage $275
    - Package of 6 60-minute massage $540

- Packages are to be used by one person and cannot be shared.