



LINNI A. FOYE-AUFDENBERG, LMT
 2727 NACOGDOCHES RD.
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 210-568-9061
WWW.METTAMASSAGECLINIC.COM

CLIENT INFORMATION AND QUESTIONNAIRE



NAME _____ HOME PHONE (____) _____ CELL (____) _____

ADDRESS _____ BEST(S) TIME TO CALL _____

CITY _____ STATE _____ ZIP _____ EMAIL _____

DOB _____ OCCUPATION _____ WORK HOURS _____

IN CASE OF EMERGENCY _____ PHONE (____) _____

PHYSICIAN _____ PHONE (____) _____

HEALTH INSURANCE CARRIER _____

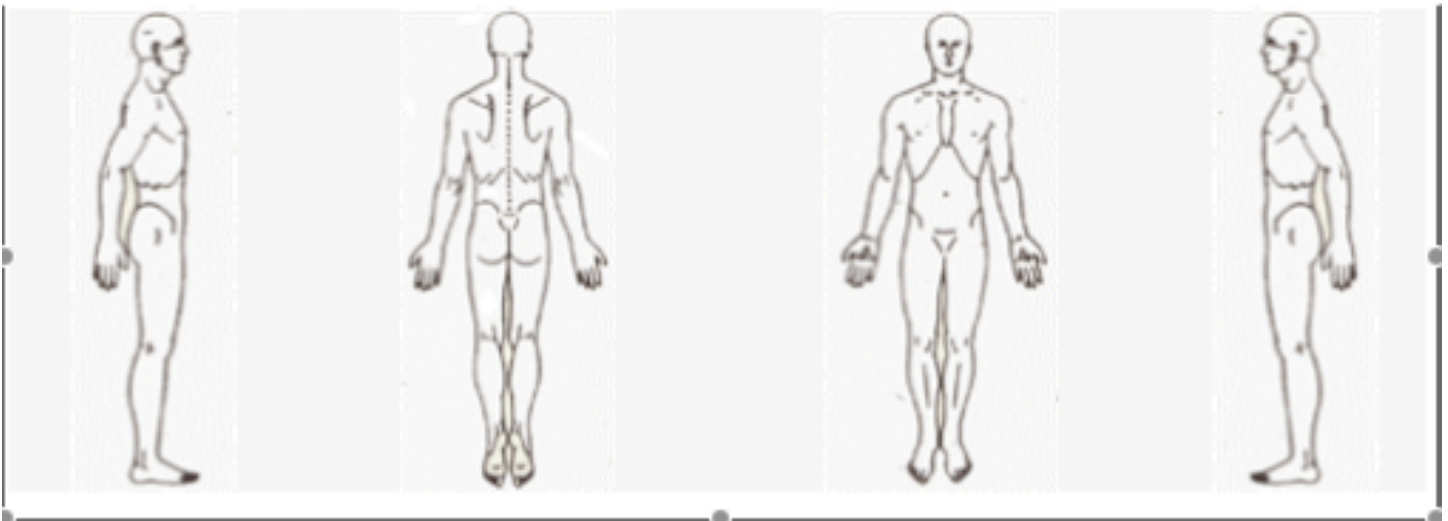
HOW DID YOU HEAR ABOUT ME? WHO REFERRED YOU? _____

REASON FOR CALLING/PURPOSE OF MASSAGE (RELAXATION/ADDRESSING AN INJURY) _____

DESCRIPTION OF INJURY _____

CONTRAINDICATIONS _____

PLEASE INDICATE WITH AN (X), IF ANY, THE AREAS IN WHICH YOU ARE FEELING DISCOMFORT:



HAVE YOU PREVIOUSLY HAD A MASSAGE (CIRCLE PLEASE)? YES NO

IF SO, BY WHOM _____

WHEN? _____ FREQUENCY? _____ MODALITY (TYPE) USED? _____



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WHAT TYPE OF PRESSURE DO YOU PREFER (PLEASE CIRCLE)? LIGHT MEDIUM FIRM

ARE YOU WEARING (PLEASE CIRCLE): CONTACT LENSES HEARING AID HAIRPIECE

PLEASE CIRCLE OR CLEARLY MARK ANY AREAS THAT YOU WISH NOT TO RECEIVE MASSAGE:

SCALP FACE NECK SHOULDERS UPPER ARMS LOWER ARMS HANDS FEET LOWER LEGS
 UPPER LEGS GLUTEALS LOWER BACK MID-BACK PECTORALS ABDOMINAL

THE FOLLOWING SOMETIMES OCCURS DURING MASSAGE. THEY ARE NORMAL RESPONSES TO RELAXATION. TRUST YOUR BODY TO EXPRESS WHAT IT NEEDS TO:

- NEED TO MOVE OR CHANGE POSITION * SIGHING, YAWNING, CHANGE IN BREATHING
- STOMACH GURGLING * EMOTIONAL FEELINGS AND/OR EXPRESSION
- MOVEMENT OF INTESTINAL GAS * ENERGY SHIFTS * FALLING ASLEEP * MEMORIES

WHAT QUESTIONS OR CONCERNS MIGHT YOU HAVE? _____

EXPECTATIONS _____

TEXAS STATE LAW REQUIRES I INFORM YOU OF THE FOLLOWING:

I WILL NOT ENGAGE IN ANY FORM OF BREAST MASSAGE ON FEMALE CLIENTS. IF MEDICALLY NECESSARY, A PHYSICIAN'S PERMISSION FORM WILL BE REQUESTED. OR, IF A DIRECT REQUEST IS MADE BY THE CLIENT, WRITTEN CONSENT WILL BE OBTAINED FROM BOTH CLIENT AND THERAPIST. PLEASE INITIAL HERE THAT YOU UNDERSTAND THIS STATEMENT



DRAPING WILL BE USED THROUGHOUT THE SESSION. PLEASE INITIAL HERE THAT YOU UNDERSTAND THIS STATEMENT.



IF FOR ANY REASON AND/OR ANYTIME YOU BECOME UNCOMFORTABLE, YOU MAY ASK ME TO END THE MASSAGE SESSION. PLEASE INITIAL HERE THAT YOU UNDERSTAND THIS STATEMENT.



PLEASE TAKE A MOMENT TO CAREFULLY READ THE FOLLOWING INFORMATION. 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 PERFORMED.



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IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, PLEASE EXPLAIN AS CLEARLY AS POSSIBLE

Medications: _____

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Please use back of form to explain all checked conditions

Client initials _____

Musculo-Skeletal

- Headaches
- Joint stiffness/swelling
- Spasms/cramps
- Broken/fractured bones
- Strains/sprains
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Leg, foot pain
- Chest, ribs, abdominal pain
- Problems walking
- Jaw pain/TMJ
- Tendonitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone or joint disease
- Other: _____

Circulatory and Respiratory

- Dizziness
- Shortness of breath
- Fainting
- Cold feet or hands
- Cold sweats
- Swollen ankles
- Pressure sores
- Varicose veins
- Blood clots
- Stroke
- Heart condition
- Allergies
- Sinus problems
- Asthma
- High blood pressure
- Low blood pressure
- Lymphedema
- Other: _____

Skin

- Rashes
- Allergies
- Athlete's Foot
- Warts
- Moles
- Acne
- Cosmetic surgery
- Other: _____

Digestive

- Nervous stomach
- Indigestion
- Constipation
- Intestinal gas/bloating
- Diarrhea
- Diverticulitis
- Irritable bowel syndrome
- Crohn's Disease
- Colitis
- Adaptive aids
- Other: _____

Nervous System

- Numbness/tingling
- Twitching of face
- Fatigue
- Chronic pain
- Sleep disorders
- Ulcers
- Paralysis
- Herpes/shingles
- Cerebral Palsy
- Epilepsy
- Chronic Fatigue Syndrome
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's disease
- Spinal cord injury
- Other: _____

Reproductive System

- Pregnancy:
 - Current
 - Previous
- PMS
- Menopause
- Pelvic Inflammatory Disease
- Endometriosis
- Hysterectomy
- Fertility concerns
- Prostate problems

Other

- Loss of appetite
- Forgetfulness
- Confusion
- Depression
- Difficulty concentrating
- Drug use _____
- Alcohol use _____
- Nicotine use _____
- Caffeine use _____
- Hearing impaired
- Visually impaired
- Burning upon urination
- Bladder infection
- Eating disorder
- Diabetes
- Fibromyalgia
- Post/Polio Syndrome
- Cancer
- Infectious disease (please list) _____
- Other congenital or acquired disabilities (please list) _____
- Surgeries _____
- Other: _____

Comments _____



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CLIENT CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPTIONS

I _____ GIVE CONSENT TO _____
FOR THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION (PHI) FOR THE SPECIFIC PURPOSES OF
PROVIDING TREATMENT TO ME, RECEIVING PAYMENT FOR SERVICES RENDERED TO ME AND FOR GENERAL
ADMINISTRATIVE OPERATIONS OF THE PRACTICE.

I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST RESTRICTIONS ON THE USE AND DISCLOSURE OF MY PHI, BUT
THE PRACTICE IS NOT REQUIRED TO AGREE TO THESE RESTRICTIONS. IF THE PRACTICE AGREES WITH MY
RESTRICTIONS, THE RESTRICTION IS BINDING ON THE PRACTICE.

YOU MAY CONTACT ME FOR APPOINTMENT REMINDERS, SCHEDULE CHANGES, OR OTHER NEEDS BY THE FOLLOWING
METHODS (PLEASE MAKE SURE YOU HAVE FILLED OUT THE APPROPRIATE INFORMATION ON YOUR CLIENT
INFORMATION PAGE)

CHECK IF YOU WOULD LIKE TEXT MESSAGE APPOINTMENT REMINDERS _____

CHECK IF YOU WOULD LIKE E-MAIL MESSAGE APPOINTMENT REMINDERS _____

CHECK IF YOU WOULD LIKE PHONE CALL MESSAGE APPOINTMENT REMINDERS _____

MARKETING: OCCASIONALLY I POST NEWSLETTERS, ANNOUNCEMENTS AND SPECIAL OCCASION CARDS. IF YOU DO
NOT WISH TO RECEIVE A NOTICE, PLEASE INITIAL HERE. _____

I HAVE READ THE NOTICE AND UNDERSTAND THIS AUTHORIZATION FORM. I UNDERSTAND THAT I DO NOT HAVE TO
SIGN THIS AUTHORIZATION AND THAT MY REFUSAL TO SIGN WILL NOT AFFECT MY ABILITIES TO OBTAIN TREATMENT,
NOR WILL IT AFFECT MY ELIGIBILITY FOR BENEFITS. I ALSO UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION
AT ANY TIME BY NOTIFYING THE PRACTITIONER IN WRITING.

PRINT NAME (CLIENT OR PERSONAL REPRESENTATIVE) _____

DATE _____

CLIENT (OR REP) SIGNATURE _____ DATE _____

CANCELLATION POLICY: PLEASE READ CAREFULLY

I UNDERSTAND THAT UNANTICIPATED EVENTS HAPPEN OCCASIONALLY IN EVERYONE'S LIFE. BUSINESS MEETINGS,
PROJECT DEADLINES, FLIGHT DELAYS, CAR PROBLEMS, SNOWSTORMS, AND ILLNESS ARE JUST A FEW REASONS WHY ONE
MIGHT CONSIDER CANCELING AN APPOINTMENT. IT IS MY DESIRE TO BE EFFECTIVE AND FAIR TO ALL OF MY CLIENTS AND
OUT OF CONSIDERATION FOR EVERYONES' TIME, I HAVE ADOPTED THE FOLLOWING POLICIES:

24 HOUR ADVANCE NOTICE IS REQUIRED WHEN CANCELING AN APPOINTMENT. THIS ALLOWS THE OPPORTUNITY FOR
SOMEONE ELSE TO SCHEDULE AN APPOINTMENT. IF YOU ARE UNABLE TO GIVE 24 HOURS ADVANCE NOTICE YOU WILL BE
CHARGED THE **FULL AMOUNT** OF YOUR APPOINTMENT. THIS AMOUNT MUST BE PAID PRIOR TO YOUR NEXT SCHEDULED
APPOINTMENT.

No-SHOWS

ANYONE WHO EITHER FORGETS OR CONSCIOUSLY CHOOSES TO FORGO THEIR APPOINTMENT FOR WHATEVER REASON
WILL BE CONSIDERED A "NO-SHOW". THEY WILL BE CHARGED FOR THEIR "MISSED" APPOINTMENT AND FUTURE SERVICE
WILL BE DENIED UNTIL PAYMENT IS MADE.



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ARRIVING LATE

APPOINTMENT TIMES HAVE BEEN ARRANGED SPECIFICALLY FOR YOU. IF YOU ARRIVE LATE YOUR SESSION MAY BE SHORTENED IN ORDER TO ACCOMMODATE OTHERS WHOSE APPOINTMENTS FOLLOW YOURS. DEPENDING UPON HOW LATE YOU ARRIVE, IT WILL THEN DETERMINE IF THERE IS ENOUGH TIME REMAINING TO START A TREATMENT. REGARDLESS OF THE LENGTH OF THE TREATMENT ACTUALLY GIVEN, **YOU WILL BE RESPONSIBLE FOR THE "FULL" SESSION.** OUT OF RESPECT AND CONSIDERATION TO YOUR THERAPIST AND OTHER CUSTOMERS, PLEASE PLAN ACCORDINGLY AND BE ON TIME.

PLEASE INITIAL HERE THAT YOU UNDERSTAND THIS STATEMENT. _____

DISCLOSURE AND DISCLAIMER STATEMENT:

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 OF WHICH I AM AWARE. I UNDERSTAND THAT MASSAGE/BODYWORK 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 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 BEING UNDER THE INFLUENCE OF DRUGS AND/OR ALCOHOL IS A CONTRAINDICATION FOR MASSAGE AND MY THERAPIST WILL TERMINATE THE SESSION. 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.

CLIENT SIGNATURE _____ DATE _____

PRACTITIONER SIGNATURE _____ DATE _____

SHOWER FACILITIES:

PLEASE READ CAREFULLY BEFORE SIGNING

USE OF SHOWER FACILITIES INVOLVES A RISK OF ACCIDENTAL INJURY DESPITE ALL SAFETY PRECAUTIONS. I WILL TAKE ALL PRECAUTIONS AND WILL IMMEDIATELY INFORM EMPLOYEES, MANAGERS OR MEMBERS OF METTA MASSAGE CLINIC PLLC OF ANY IDENTIFIED HAZARDS AND INFORM METTA MASSAGE CLINIC PLLC OF MY INTENTION TO USE THE ON SITE SHOWER FACILITIES AT THE BEGINNING OF MY THERAPY SESSION. I/WE, AS AN INDIVIDUAL OR AS A PARENT OR GUARDIAN OF THE CLIENT NAMED HEREIN, ASSUME ALL RISKS AND HAZARDS INCIDENTAL TO THE USE OF SHOWER FACILITIES, AND RELEASE FROM RESPONSIBILITY AND AGREED TO INDEMNIFY AND HOLD HARMLESS METTA MASSAGE CLINIC PLLC, ITS OFFICERS, DIRECTORS, MEMBERS AND ALL EMPLOYEES FOR INJURY TO ME IF I CHOOSE TO USE THE SHOWER FACILITIES DIRECTLY FOLLOWING A MASSAGE.

SIGN BELOW ONLY AFTER CAREFULLY READING THE ABOVE.

CLIENT SIGNATURE _____ DATE _____

PRACTITIONER SIGNATURE _____ DATE _____