Alternative Healing Solutions, LLC
www.DenverAlternativeHealing.com
720.HEALME2 (432-5632)

New CLIENT REGISTRATION

Date: _____

Name: _____ Gender: ☐M ☐F Date of Birth: _____

Address:_____Zip: _____
Home Phone: _____ Cell Phone: _____Email_____

Where do you work, what do you do: _____
Emergency Contact _____Phone _____

Please provide the following information to the best of your knowledge. Any information provided will be considered confidential. This information is necessary for the safety of both yourself and your therapist, and will greatly aid in the most appropriate evaluation of your condition and the recommendations for your treatment. We use a combination of techniques to free our clients from pain including but not limited to: Swedish massage, myofascial release, range of motion technique, therapeutic exercise, stretching, hot stones, breathing, and deep tissue release.

Medical History and Information

Please check any condition listed below that applies to you:

☐ Contagious skin condition	☐ Open sores or wounds	☐ Easy bruising
☐ Recent accident or injury	☐ Recent fracture	☐ Recent surgery
☐ Artificial joint	☐ Sprains/strains	☐ Current fever
☐ Swollen glands	☐ Allergies/sensitivity	☐ Heart condition
☐ High or low blood pressure	☐ Circulatory disorder	☐ Varicose veins
☐ Atherosclerosis	☐ Phlebitis	☐ Deep vein thrombosis/blood clots
☐ Joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis		☐ Osteoporosis
☐ Epilepsy	☐ Headaches/migraines	☐ Cancer
☐ Diabetes	☐ Decreased sensation	☐ Back/neck problems
☐ Fibromyalgia	☐ TMJ	☐ Carpal tunnel syndrome
☐ Tennis elbow	☐ pregnancy If yes, how many months?_____	

Other not listed_____
_____
List all medications/herbs/vitamins and dosage: _____
_____
What movements or activities are limited? What aggravates it? _____
_____
List previous major injuries/surgeries: _____
_____
Please let us know how you found us? _____
Legal Issues: Is your injury related to a car accident or work injury? ☐**Yes** ☐ **No**
Legal counsel's name & phone number (if applicable): _____
Are you ***CLEARED*** for massage? ☐**Yes** ☐ No
What other treatments are you receiving and by whom (acupuncture, physical therapy, chiropractic, naturopathic):
_____
Is there anyone you want us to copy on your treatment progress? ☐**Yes**☐**No** If Yes, what is your doctors /practitioners:
Name: _____ Phone number: _____
Name: _____ Phone number: _____
Name: _____ Phone number: _____

Take the time to tell us for your visit today: _____

_____

_____

_____

_____

_____

_____

_____

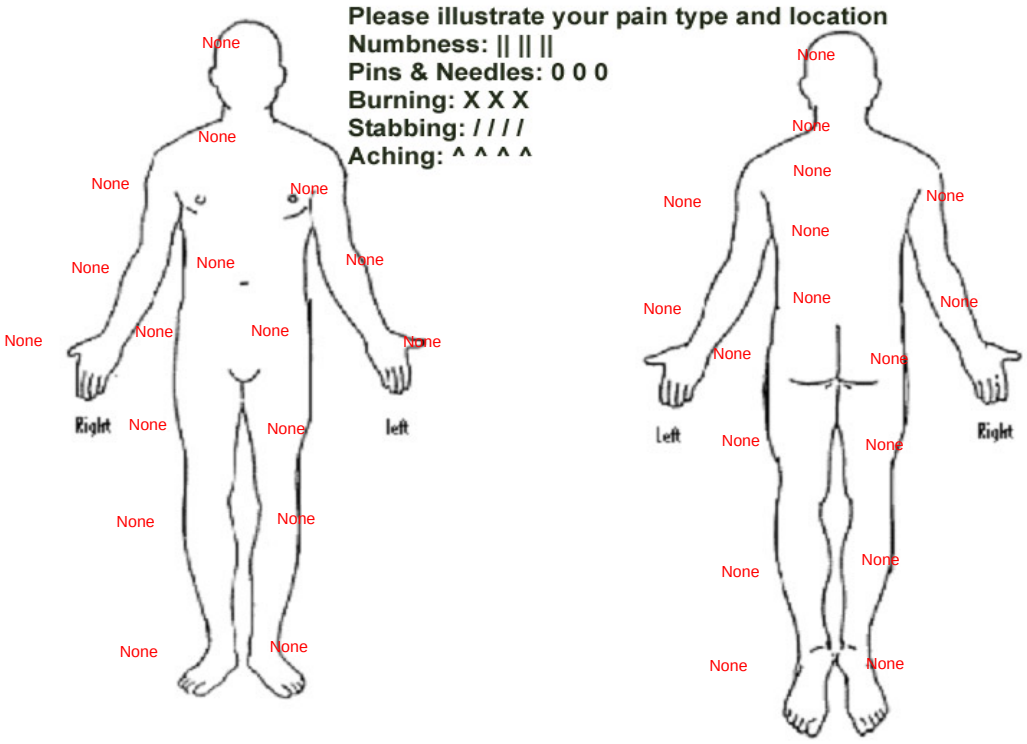
What are your outcomes for today session?: _____

_____

_____

_____

_____



Client Signature: _____ Print Name: _____

Today's Date:_____

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Alternative Healing Solutions, LLC Informed Consent & Policy Agreement

I, _____, understand that massage therapy provided by, *Alternative Healing Solutions, LLC* is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy. I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep Alternative Healing Solutions, LLC & therapist updated on any changes. I understand that there shall be no liability on Alternative Healing Solutions, LLC & the practitioner's part due to my forgetting to relay any pertinent information. If I experience any pain or discomfort during the session, I immediately communicate that to the therapist so the treatment can be adjusted. I have reviewed the therapist's policies, and I understand them and agree to abide by them. I acknowledge that with any treatment there can be risks and I assume all those risks. You will be draped during the massage for your safety and comfort, and only the part of the body being worked will be exposed. If at any time you are uncomfortable with any aspect of the massage, whether it be draping, the amount of pressure used, or even the room temperature, please feel free to communicate this to your therapist. It is important that you feel comfortable in order to receive the full benefit of massage. Breast massage of female clients is prohibited unless we receive medical orders from your physician along with client's written consent and approved by head staff member. All massage services provided are strictly non-sexual. Your therapist will end the session if at any time behavior becomes inappropriate. If you feel uncomfortable at any time you may ask your therapist to end the session. Full payment for entire session will still be required. This office maintains a 24-hour cancellation policy. If there is a situation that prevents you from notifying this office of your need to reschedule within 24 hours prior to your scheduled appointment, our policy for cancellation is to give 24-hour notice. If you do not give notice you will be charged a $25 fee at your next appointment prior to session. The 2nd time it happens and anytime thereafter, you are charged for the full price of the massage missed/No Show. Emergency cancellations are determined at the practitioner's discretion. We ask that you arrive to your scheduled appointment on time. We schedule enough time in between appointments to allow for evaluation and discussion with each client. If we need to start your session late because you did not arrive on time, we will still need to end your session at the scheduled completion, so that we may provide the next client the same amount of attention. We will also require full payment for your scheduled session. *Alternative Healing Solutions, LLC* are not responsible for the loss of your valuables or personal property. Please check the room for your valuables, such as jewelry and glasses before exiting your session. I understand that massage therapists 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 should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly.

Client Signature: _____ Print Name: _____

Today's Date:_____