

E S S E N T I A L T H E R A P I E S

392-4325 www.E-Therapies.Net

1313 E Center St Kingsport 402 E Unaka Ave Johnson City

CONFIDENTIAL INFORMATION

Name _____ Phone # (H) _____ (W) _____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Gender _____ Marital Status _____
Occupation _____ Height _____ Weight _____ # Children _____
Referred By _____ May we acknowledge the referral with a thank you? _____

If you would like to be on our email list, put your address here: _____

What is your goal today with regard to your treatment?

In what particular areas of your body have you noticed tension or discomfort?

What activities aggravate your condition?

Is this condition constant or has it been changing?

Is this condition interfering with your Work _____ Sleep _____ Daily Routine _____

Have you had a professional diagnosis? _____ If yes, what was the diagnosis? _____

By Whom? _____ Address _____ Phone _____

May we contact this professional regarding our findings? _____

Please list any medications you are taking. _____

Please list any nutritional supplements (herbs, vitamins, nutraceuticals) you are taking _____

Have you ever or do you now have any of the following? Put a P for Past or C for Current

_____ Allergies to Oil or Perfumes	_____ Diabetes	_____ Neck, Mid or Lower Back Pain
_____ Varicose Veins	_____ Headaches	_____ High Blood Pressure
_____ Decreased Range of Motion	_____ Pregnancy	_____ Persistent Abdominal Pains
_____ Nervous Tension	_____ Sprains	_____ Joint Aches
_____ Broken Bones	_____ Seizures	_____ Constipation
_____ Operations	_____ Accident	_____ Whiplash

Please Provide More Detail About Any Issues You Checked Above or Add Any Additional Information About Yourself.

Hobbies? Exercise? Diet? Stresses? _____

(Don't Forget Page 2)

Have you ever received a massage before?

Do you now have any of the following?

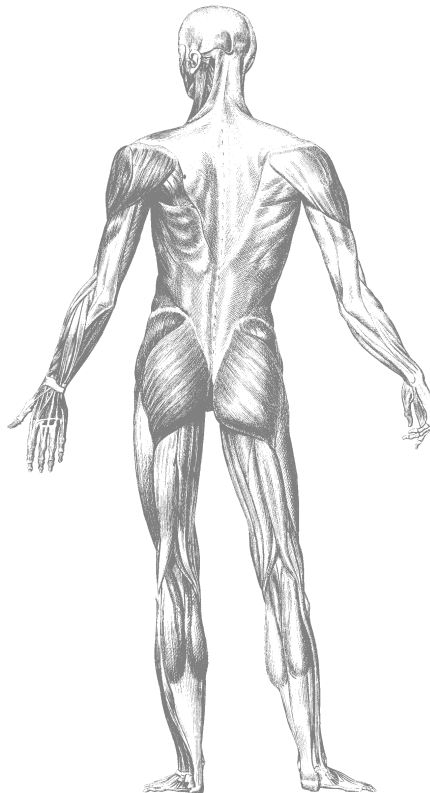
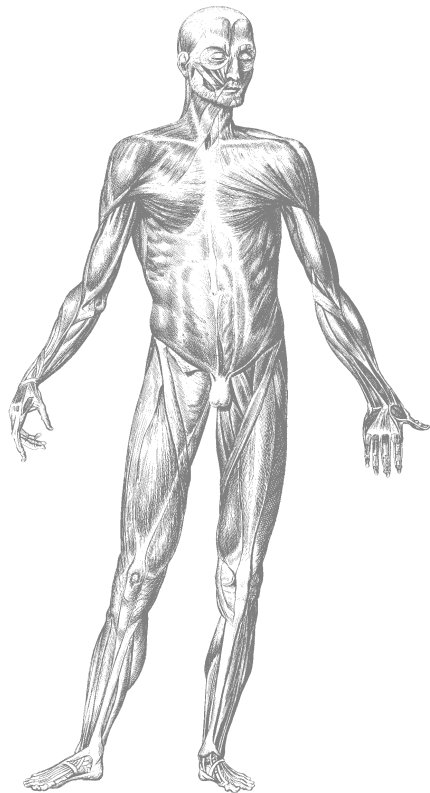
_____Irritated skin or rash

_____Sunburn

_____Open cuts, burns or bruises

_____Inflammation

Please indicate below the places that you are feeling discomfort.



Provide additional information here

Horizontal lines for providing additional information.

Horizontal lines for marking discomfort on the anatomical drawings.

I consent to have Essential Therapies provide therapeutic massage, wellness / nutritional consultation, and spa treatments. I understand that the services provided by Essential Therapies are for general wellness purposes and that I should see a primary care provider or physician for diagnosis and treatment of any suspected medical problem. I also understand that it is my responsibility to keep Essential Therapies informed of any changes in my health, and any medications that I may begin to take in the future. I understand that Essential Therapies does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of the therapy offered here. I have answered all questions fully and disclosed any medical conditions.

For your comfort, you will remain comfortably draped with a sheet or towel at all times during your massage. Some people take off all of their clothes. Others leave all of their clothes on. It is your choice. No matter how much you take off or leave on, your privacy will be respected.

I understand that Essential Therapies has a 24 hour cancellation policy. If I must cancel my appointment, I will do so with greater than 24 hours notice or I agree to pay for the session. I also understand that if Essential Therapies must cancel my appointment without 24 hours notice, I get my next treatment free.

If I have a dissatisfaction or concern about my treatment, I will address my concern first with my massage therapist. He or she may request that I submit such concerns in writing to ensure clarity. If any concerns cannot be resolved, I agree to mediation, as a binding decision by the laws of Tennessee, to resolve any conflicts or dissatisfaction with my treatment.

Signed _____ Date _____