

CLIENT INFORMATION and HEALTH HISTORY

Name: _____ Today's Date: _____
 Address: _____ Home Phone: _____
 City, State, Zip: _____ Cell Phone: _____
 Occupation: _____ Work Phone: _____
 Date of Birth: _____ Email Address: _____

Please let us know how you heard about The BrickHouse? _____

This profile should be filled out completely to allow your therapist to correctly evaluate your needs for the services you will receive at The BrickHouse. This information is confidential and to be used by the Licensed Therapist only.

PLEASE INDICATE ANY CONDITIONS THAT APPLY TO YOUR HEALTH HISTORY:

C = Current or P = Past

- | | |
|--|--|
| <p>_____ Current Pain or Discomfort? _____
 Where? _____
 When did it start? _____
 Interferes with normal activities?
 Work? ___ Sleep? ___ Other? ___
 Medical Diagnosis? _____
 What brings relief? _____</p> <p>_____ Broken Bones
 _____ Severe Strains or Sprains
 _____ Numbness / Tingling
 _____ Jaw pain / TMJ
 _____ Tendonitis: _____
 _____ Bursitis: _____
 _____ Arthritis: _____
 _____ Osteoporosis / Bone or Joint Disease
 _____ Ulcers
 _____ Shortness of breath
 _____ Asthma / Sinus Problems
 _____ Chronic Pain: _____
 _____ Pregnant: Due date: _____
 _____ Surgeries: _____

 _____ List allergies: _____

 _____</p> | <p>_____ Skin Conditions
 _____ Scoliosis
 _____ Multiple Sclerosis
 _____ Spinal Cord Injury
 _____ Crohn's Disease / Digestive disorders
 _____ HIV / AIDS
 _____ Diabetes: _____
 _____ Fibromyalgia
 _____ Temperature Sensitivity:
 Hot? ___ Cold? ___
 _____ Depression
 _____ Cancer: _____
 _____ Infectious Diseases: _____
 _____ Pacemaker / Metal Implant
 _____ Heart Condition / Chest Pain
 _____ Stroke
 _____ Blood Clots / Varicose Veins
 _____ High / Low Blood Pressure
 _____ Epilepsy</p> <p>_____ Current Medications:

 _____</p> |
|--|--|

**I have stated all conditions that I am aware of and this information is true and accurate.
 I will inform The BrickHouse of any changes in my status.**

SIGNED: _____

CLIENT INFORMATION and HEALTH HISTORY, continued

Health Insurance Company _____ Physician _____
Phone _____
Emergency Contact _____ Phone _____
Relationship to me _____

INFORMED CONSENT FOR ALL SERVICES

(Massage Therapy, Body Treatments, Facials, Skin Care, Waxing, Manicures, Pedicures, Spa Parties)

As a condition upon which the BrickHouse Massage & Coffee Bar has agreed to provide a service to the undersigned, the client does hereby assume all risks of personal injury from the application of any or all products to include skin reactions. I understand that manual therapy is intended to reduce discomfort, increase range of motion, improve circulation, enhance relaxation and offer a positive experience.

I understand that the general benefits and contraindications of manual therapy, body treatments and skin care have been explained to me. I understand that my treatment is in no way a replacement for medical treatments or medications. The BrickHouse recommends that I work concurrently with my primary care provider for any conditions that I may have. I am also aware that none of the therapists employed by the BrickHouse are qualified to diagnose illness or disease, prescribe medication or perform spinal manipulations.

I have filled out the attached Client History form including all allergies, health conditions, medications and special considerations. When I return for future treatments, I will keep my therapist updated if there have been any changes.

By signing below I agree to adhere to the following BrickHouse policies:

1. Services are by appointment only. A 24 hour cancellation is required on all individual appointments or will be subject to a 50% charge. Spa Parties and certain spa packages require a 50% deposit at the time the reservation is made. A 72 hour cancellation is required or entire deposit will be forfeited. Prices are subject to change. Prices do not include gratuity.
2. Payment is expected at the time of service. We accept cash, check and all major credit cards. Returned checks will be charged a \$25 NSF fee.

Printed Name _____

Signed _____ Date _____
(Clients full name)

Parents Signature _____ Date _____
(Legally required for clients under the age of 16 years old)