Massage Client Information

Name: ___________________________________D.O.B.______/_____/______ gender: M/F

Address: _____________________city:______________state:______zip code:__________

Primary Phone#: _____________________ Secondary Phone#:________________________

Email: _________________________ Occupation: ______________________________

Referred by: ______________ Emergency contact:____________Phone:_______________

Current Medications: ____

Primary Care Physician:________________________ Phone: _______________________

Please circle any that apply past and current:

Diabetes seizures varicose veins abdominal pain headaches/migraines

Hypertension hypotension stroke heart attack arthritis

Bursitis gout HIV surgery broken bones plantar warts

Pregnancy Allergies to oils or scents

Please circle all of the following that you are experiencing today:

Sunburn inflammation severe pain headache open cuts bruises

Blisters skin rash fever poison ivy cold/flu allergies

Infection Pregnancy

Please list any concerns or existing conditions:

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Consent for care:

It is my choice to receive manual therapy, and I give consent to receive treatment. I have reported all health conditions that I am aware of and will inform my therapist of any changes in health. I will inform my therapist any time I feel my well being is threatened or compromised. I expect my therapist to provide a safe and effective treatment. I acknowledge that therapeutic massage is not intended to medically diagnose, treat, or cure.

Signature: ______________________________________ Date: ____________________

<u>Complementary and Alternative Health Care Bill of Rights</u>

Jean Struzyk MT, CNHP
Massage Therapist
Certified Natural Health Practitioner

"THE STATE OF MINNESOTA HAS NOT ADAPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED AND COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATIONAL PURPOSES ONLY.

Under Minnesota law, and unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time."

Family Tree Health and Wellness LLC
2 Second Avenue South Suite #130
Sauk Rapids MN 56379

If you have any complaints about your therapy and wish to file a complaint to the government about your therapy, the address is:
Office of Unlicensed Complementary and Alternative Health Care Practice
MN Dept. of Health
Health Occupations Program
PO Box 64975
St. Paul, MN 55164-0975
Phone: 651.282.5623 Fax: 651.282.5628 Web: www.health.state.mn.us

Fees: Payment is due at the time of service
EDS (Electro Dermal Screen) Service is not covered by insurance
~ Initial $120; Follow-up $45; Child Initial $60; Child Follow-up $30
Massage Therapy: Service is not covered by insurance
~ ½ hour $35; 1hour $60-$90

You as a client will have reasonable notice of changes in services or charges. You have a right to complete and current information concerning my assessment and recommended services that is to be provided. You as a client may expect courteous treatment that is free from any physical of emotional abuse.

Other Massage Therapists and Electrodermal (EDS) technicians may be found in the phone book. You may choose freely among the available practitioners and change practitioners after services have begun. I will be happy to transfer any information you may request if another practitioner is requested. At any time during a session you may refuse services or treatment, unless otherwise provided by law; and you may assert your rights without retaliation.

Client signature: _______________________________Date: ____________________