

Amy Campbell
LMT, CIMI, CPMT
Art Walk Massage
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Therapy & Instruction  
For all ages



30 Allens Creek Road  
[www.ArtWalkMassage.com](http://www.ArtWalkMassage.com)  
[amy@artwalkmassage.com](mailto:amy@artwalkmassage.com)  
585-545-5641  
585-442-3320

Name \_\_\_\_\_ Phone 1 \_\_\_\_\_ Phone 2 \_\_\_\_\_

Address \_\_\_\_\_ zip code \_\_\_\_\_

Email \_\_\_\_\_ Birth date \_\_\_\_\_

Employer \_\_\_\_\_ Emergency Name/phone \_\_\_\_\_

Reason(s) for seeking massage therapy \_\_\_\_\_

Referred by \_\_\_\_\_ PCP Name /phone \_\_\_\_\_

Other Health Care Providers (chiropractor, herbalist, etc) \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Are you basically in good health? \_\_\_\_\_

Have there been any changes in your health in the past year, or surgeries in the past year? \_\_\_\_\_

If yes, please explain \_\_\_\_\_

List all medications/herbs/vitamins and dosage: \_\_\_\_\_

List physical activities you participate in regularly \_\_\_\_\_

Please describe anything else you think I should be aware of \_\_\_\_\_

Check any or all that apply to your present health:

- |                                                   |                                              |                                               |
|---------------------------------------------------|----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> _headaches               | <input type="checkbox"/> _fatigue            | <input type="checkbox"/> _epilepsy/seizures   |
| <input type="checkbox"/> _chronic pain            | <input type="checkbox"/> _scoliosis          | <input type="checkbox"/> _diabetes            |
| <input type="checkbox"/> _varicose veins          | <input type="checkbox"/> _cancer/tumors      | <input type="checkbox"/> _phlebitis/clotting  |
| <input type="checkbox"/> _vision problems         | <input type="checkbox"/> _depression         | <input type="checkbox"/> _joint swelling      |
| <input type="checkbox"/> _muscle / joint pain     | <input type="checkbox"/> _arthritis          | <input type="checkbox"/> _bruise easily       |
| <input type="checkbox"/> _sinus problems          | <input type="checkbox"/> _infectious disease | <input type="checkbox"/> _allergies *         |
| <input type="checkbox"/> _high blood pressure     | <input type="checkbox"/> _sleep difficulties | <input type="checkbox"/> _heart conditions *  |
| <input type="checkbox"/> _low blood pressure      | <input type="checkbox"/> _tendonitis         | <input type="checkbox"/> _numbness/tingling * |
| <input type="checkbox"/> _jaw pain/teeth grinding | <input type="checkbox"/> _skin problems      |                                               |
| <input type="checkbox"/> _sprains/strains         | <input type="checkbox"/> _osteoporosis       |                                               |

\*allergies, heart conditions, numbness:

\_\_\_\_\_

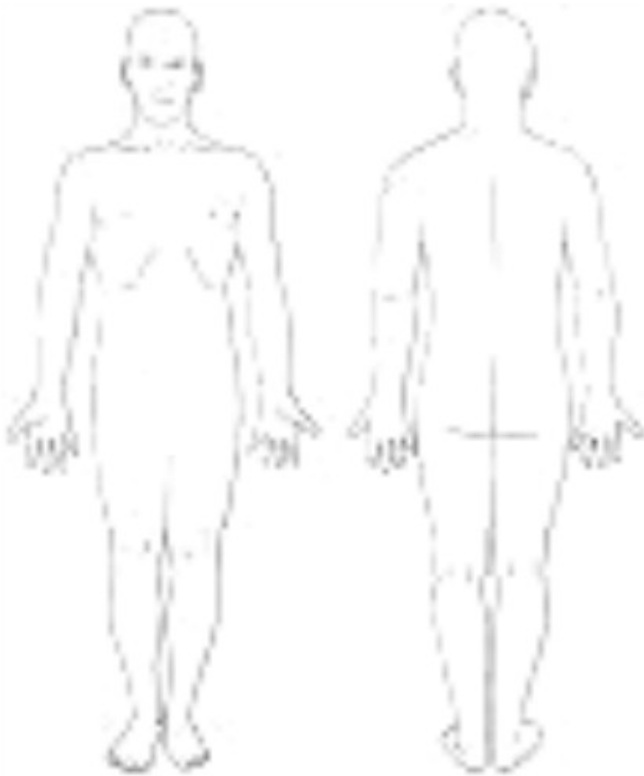
**Women** only: Pregnant \_\_\_ Due date: \_\_\_\_\_ Painful menstruation \_\_\_ endometriosis \_\_\_

**Men** only: Prostrate problems \_\_\_

What is your main activity at work? Phone \_\_\_ Sitting \_\_\_ Computer work \_\_\_ Driving \_\_\_ Walking \_\_\_ Other \_\_\_\_\_

What do you do to relieve stress

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Please use the diagram to the left to show any areas that are troublesome to you.

Please show this by marking these spots. Feel free to make notes (such as "pain", "spasms" etc.)

I agree to provide **24 hour** cancellation notice (except in an emergency). If I fail to do so, I agree to pay the **full** appointment fee. (Please note that insurance companies **do not** pay this, you do.)

I am responsible for all charges for all services provided. In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due.

I understand that the services provided are not a replacement for medical or psychological care and that any information provided is not prescriptive or diagnostic in nature and it is for educational purposes only. I have stated all medical conditions that I am aware of and will inform my practitioner of any change in my medical status. I also give my permission to Amy Campbell, LMT to discuss information pertinent to my condition(s) and treatment with my other health care providers. I hereby authorize the release of medical information necessary to process my insurance claim. Additionally, I understand the client therapist relationship will be held in strict confidence.

**Print Name** \_\_\_\_\_ **Signature** \_\_\_\_\_

Date \_\_\_\_\_

Consent to Treatment of Minor: By my signature below, I hereby authorize Amy Campbell, LMT to administer massage therapy techniques to my child or dependant, \_\_\_\_\_, as she deems necessary. I have been invited to stay at all times during the massage session.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_