



107 East First Street  
Clayton, NC 27520  
919-270-4892

## Confidential Client Information

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Mobile phone #: \_\_\_\_\_ Other/Work# : \_\_\_\_\_

In Case of Emergency: name \_\_\_\_\_ relationship to you \_\_\_\_\_

Emergency contact phone # and email \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Referred By: \_\_\_\_\_

**What is the purpose for this visit?** \_\_\_\_\_

Have you received massage/bodywork before? \_\_\_\_\_

If yes, how would you describe your experience? \_\_\_\_\_

On a scale of 1-10, rate your average daily stress level: \_\_\_\_\_

Do you exercise regularly? If so, in what way and how often?  
\_\_\_\_\_

\_\_\_\_\_

Are you wearing contacts? \_\_\_\_\_

# Office Policies

*Please take a moment to carefully read the following information and sign where indicated:*

I understand that the massage therapy I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my comfort level.

I understand that massage therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of.

I understand that massage therapy practitioners 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 therapy should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability of the practitioner's part should I forget to do so.

I agree that all services rendered to me are charged directly to me and I am responsible for payment unless prior arrangements have been made. **A 24-hour minimum notice is required for cancellations. We reserve the right to charge full price for any missed or un-cancelled appointments.** The exception to this rule is illness or emergency. For the purpose of preventing the spread of infectious or contagious illness (i.e. cold, flu); if I am or becoming ill I agree to act responsibly and cancel my appointment and no fees will be charged or owed. I also agree that if my practitioner is ill or becoming ill the same will hold true.

## **Rates:**

\$85.00 60-minute session	\$55.00 30-minute session	\$70 45-min session
\$100.00 75-minute session	\$115.00 90-minute session	\$140.00 120-minute session

Specialty Services Rate: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Thank you for your cooperation and the opportunity to help you with a truly effective therapeutic massage at Purna Yoga East. If you have any questions, please ask your therapist. We are here to assist you any way we can.**

*In good health,  
Your Purna Yoga East Massage Therapist*