Vital Harmony Therapeutic Massage

Michelle S Krause LMT Severna Park MD 21146 410-703-2144

Name		_ DOB
Address	City/State/Zip	
Primary Phone	Secondary Phone	
Email	(your email will not be shared)	
How did you hear about u	s?	
Occupation	Employer	
Emergency Contact	Phone	
Reason for today's visit? _		
Have you ever had a profe	essional massage before? Yes	No
Are you pregnant or trying	y to get pregnant? Yes	No
	ou? AVE/HAD ANY OF THE FOLLOV	WING CONDITIONS
—Heart Conditions Skin Disorders	High Blood Pressure Immune Disorders	Vascular/Blood Disorders Stomach Disorders
Diabetes Arthritis Broken Bones Sciatic Pain	Cancer Allergies/food/products Headaches Wear Contacts	— —Respiratory Disorders —Back or Chest Aches —Neck/Shoulder Pain —TMJ
Edema	Breast Augmentation	Radiation/Chemo Treatments

Please read the following, initial and sign below:

___Be aware that our Licensed Massage Therapist has a wide variety of Advanced Training. Techniques to be used include Myofascial Release, Trigger Point, Swedish, Visceral Manipulation, Manual Lymphatic Drainage, Craniosacral Therapy (CST), Somato Emotional Release (SER), Muscle Energy Techniques, Range of Motion, Stretching, Pregnancy massage, Neuromuscular, Hot Stone, Himalayan Salt Stone, Medical Massage

___Body part to be treated include face, intraoral, neck, scalp, shoulders, arms, hands, back, bottocks, hip flexors, legs and feet. Therapists may treat muscles of the chest and ribcage, however they do not engage in massage of the breast tissue.

____This information will be treated confidentially in compliance with HIPAA Privacy Rules

___Our massage therapist utilizes only conservative training during your session. If I feel uncomfortable for any reason, I may ask to end the session.

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____I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder, nor perform spinal adjustments. Massage therapy is not a substitute for medical examinations and/or diagnosis. It is recommended that I see a physician for any physical ailment that I might have. I understand that massage therapy given here is for the purpose of, but not limited to:Fulfilling a prescription or a treating physician for a medically necessary condition or for relief from muscular spasm or fascial tension and to improve circulation.

___Because a massage therapist must be aware of existing physical conditions, I have stated all of my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

___I will respect the time of my massage therapist and other clients. I agree to come to my scheduled appointment promptly, barring any unforeseen emergency. I understand that if I cancel later than 48 hours prior to my appointment, I agree to pay HALF the cost of my appointment. If I cancel within 24 hours or NO SHOW, I agree to pay the FULL price of the appointment.

____There is a \$35 charge for each check returned unpaid.

Fees per session

One hour session-\$85 90 minute session-\$125 120 minute session-\$160 BioMat-\$15 Same Day Appointment additional-\$25 Appts Scheduled on Off Work Days additional-\$25

I have read and understand the above document and am in compliance.

Sign Print Date
Witness Print Date