

# *Endermologie*

## Personal Profile & Health History

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Family Doctor: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
What are your cosmetic areas of concern? \_\_\_\_\_

Since your lifestyle affects your body and the results of the Endermologie treatments please complete the following:

Are you pregnant? \_\_\_\_\_ Nursing? \_\_\_\_\_ In Menopause? \_\_\_\_\_  
Are you using (HRT) Hormone Replacement Therapy? \_\_\_\_\_ Are you using hormonal contraception? \_\_\_\_\_  
Have you had cosmetic or plastic surgery? \_\_\_\_\_ To what body part? \_\_\_\_\_  
Do you smoke? \_\_\_\_\_ Cigarettes/Day \_\_\_\_\_  
Drink: Water \_\_\_\_\_ oz/day: \_\_\_\_\_ Alcohol: \_\_\_\_\_ oz/day: \_\_\_\_\_ Caffeinated Beverages: \_\_\_\_\_ oz/day: \_\_\_\_\_  
Balanced Nutrition: \_\_\_ yes \_\_\_ no Diet: \_\_\_ yes \_\_\_ no  
Physical Activities: \_\_\_ yes \_\_\_ no Details: \_\_\_\_\_  
Psychological Stress: \_\_\_ yes \_\_\_ no

Please check all that apply to your medical history:

<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Burns/Skin Grafts	<input type="checkbox"/> Diabetes
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Infectious progressive diseases	<input type="checkbox"/> Implants
<input type="checkbox"/> Circulatory/Vascular Disease	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Unexplained Calf Pain	<input type="checkbox"/> taking Anti-Coagulant Medication	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Active Cancer	<input type="checkbox"/> Hernia (inguinal/abdominal)	<input type="checkbox"/> Shingles
<input type="checkbox"/> Open Sores/infected areas	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Inflammation
<input type="checkbox"/> Skin Tumors	<input type="checkbox"/> Injection sites in area being treated	

Please list any other health concerns that your technician should know about prior to treatment.

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I confirm that the answers to this questionnaire are true and correct. I agree to make the technician aware of any changes in my medical history during my treatment period.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Holten Back & Neck Center**  
**Policies**

**Payment:**

Payment is expected at the time of scheduling the massage in order to confirm your appointment. Payment will be accepted by cash, charge or check made out to Holten Back & Neck Center.

\*\* There will be a \$25.00 fee applied to any returned checks.

**Late Policy:**

If client is late for a scheduled massage, the massage will still end at the planned time. If the therapist is late, every effort will be made to ensure fairness by allotting more time or decreasing the fee.

**Cancellation Policy:**

Please give 24 hour notice for cancellations. Patients not giving 24 hour notice will be charged **\$30.00** for the *missed* scheduled appointment.

**Ethics:**

Massage is a medical procedure. Any misconduct (sexual or otherwise) is not acceptable and will not be tolerated. This will result in the immediate termination of the massage session and any further scheduling of future appointments.

**Consent For Care:**

I have completed these forms to the best of my knowledge. I understand that massage therapy is designed to be a health aid and is in no way to take the place of medical care when it is indicated. I, to the best of my knowledge, have no physical conditions that would be contraindicated for massage therapy and will inform my therapist of any changes in my health status.

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_