Sobadores del Llano and Remedios Naturales NM LLC

Date _________________ Occupation____________________

Name ____ Date of Birth ___________________

Mailing Address ____ Zip Code ____________

Phone Numbers (Day) __________________ (Evening) _________________ (Cell) _____________________

Referred By __________________________________ E-mail Address _______________________________

Emergency Contact Name _____________________ Phone (Day) ________________ (Eve) ______________

Physician's Name ____ Phone _____________________

Have you had massage before? If so, what kind(s)? ____

____

What is your primary reason for a treatment today? ____

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Please Circle any of the following conditions that pertain to you: 1) Cold/Flu with fever within the previous 24 hours, 2) Blood Pressure Problems, 3) Heart Disease, 4) Cancer (current or past personal history), 5) Skin Diseases, 6) Current Redness or Swelling in any Joints and/or 7) Currently Pregnant or Nursing a Baby

Do you have any conditions and/or diseases that have been diagnosed by a Medical doctor? Please List: ______

____

____

List all Medications, Vitamins, Herbs or other Supplements that you are currently taking: __________________

____

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____

____

Do you drink filtered or bottled water, and if so what kind: ____

____

Please Continue on Other Side>>>

Please list **ALL** surgeries and serious injuries, **including dates**, that you have ever had:___________________

Do you have areas in your body where you regularly experience pain or discomfort that are **NOT** your primary reason for treatment today? Please describe: ____

Do you have areas of your body that are ticklish, especially sensitive to touch because of a tingling or numb-like sensation and/or that actually go numb on occasion, or which are always numb? Please describe: ___________ _

Please list all allergies including hayfever (airborne pollens etc.), food allergies, allergies to drugs/medications, sensitivities to fragrances/perfumes and problems with oils or lotions: _________________________________

If you would like to submit a claim to your insurance for billing or reimbursement, please list your insurance carrier, name under which the insurance is carried, your policy identification number, and the toll-free number for your insurance company which appears on the back of your insurance card: __________________________

If this is a Workers Compensation or an Automobile or Personal Injury (PI) Insurance Claim, please list the claim number and claims adjuster name and contact number: ____

Please be aware that if we submit a bill for insurance purposes, all information provided here as well as file notes that we keep concerning your treatments will be submitted to your insurance provider.

As is true for everyone, our time is our most valuable asset. Because of this, we have established the following cancellation policy: If you must cancel your appointment with less than 24 hours notice, you must either pay the full price of the treatment or find someone else to take your appointment. Please sign below, acknowledging that the above information is true and correct to the best of your knowledge and that you understand and agree to our cancellation policy. Thank you for your understanding.

____ ______________________________

Signature Date

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