SARANA COMMUNITY ACUPUNCTURE

970 San Pablo Avenue, Albany, CA 94706 (510) 526-5056 www.saranaca.org

MASSAGE/CUPPING CLIENT FORM

Name: ____ Date: ______/______/______
(first) (middle) (last)

Address ____ City____________________ State ____ Zip Code _______

Phone # (day) ____________________________________ (evening) ____________________________________

Email Address____ Referred by ________________________________

Date of Birth: _______/_______/_______ Age: _________ Gender / Pronoun_______ Occupation _________________________

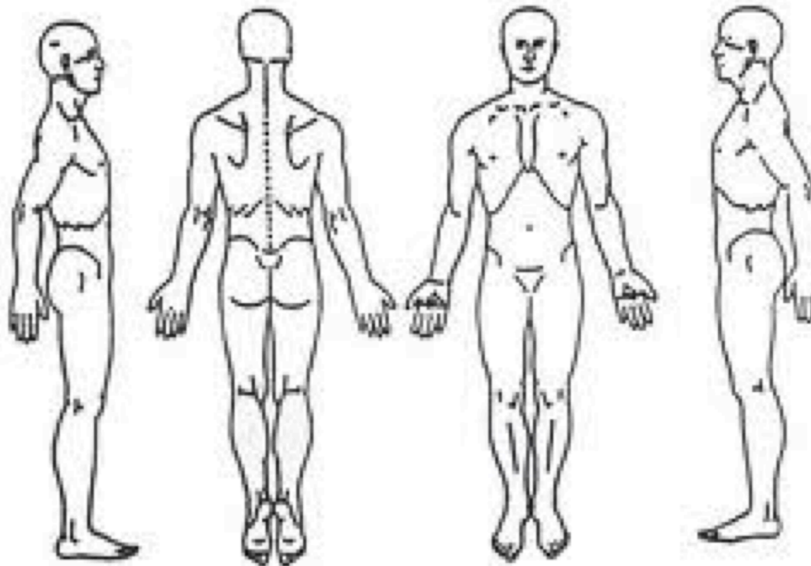
Please complete this questionnaire as thoroughly as possible. All of your answers will be held confidential within lawful limits. If you have anything you wish to bring to our attention, which is not asked on this form, please note it in the 'Comments' section. Print all information and indicate areas of confusion with a question mark. Thank you.

Have you ever received a professional massage or bodywork session? __ Yes __ No How recently?_________________________

What kind of pressure do you prefer? _____ light _____ medium _____ firm

Have you received cupping before? __ Yes __ No

Please **CIRCLE** the locations on the diagrams where you are feeling any pain / tension / discomfort **(Indicate "R" for right side, "L" for left side):**



Check if you have:

___ Diabetes
___ Epilepsy or seizures
___ Arthritis
___ High blood pressure
___ Contagious diseases
___ Numbness or stabbing pains
___ Cardiac or circulatory problems
___ Varicose veins

___ Are you pregnant?
___ Do you bruise easily?
___ Have you had any injuries or surgeries? (please list below):

____
____
____

List any other serious medical conditions and any medications we should know about?

____
____
____
____

Comment on any "yes" answers from above:____

____

____

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MASSAGE AND CUPPING - FINANCIAL POLICY AND CONSENT FORM

FEE STRUCTURE:

Massage / Acupressure $1 per minute (scheduled in 10, 20, 30, 40, 50 or 60-minute increments)
Cupping: $20 per session

CANCELLATION POLICY:

A minimum of 24 hours advance notice is requested for a change or cancellation of appointment.

A massage or cupping appointment that is missed, rescheduled or cancelled with less than 24-hour advance notice **will be charged in full** for the time booked at the $1 per minute rate for massage and $20 for a missed cupping session.

There will be a $15 fee for any returned checks.

CONSENT:

I understand that the massage therapy and /or cupping given here is for the purpose of stress reduction, relief from muscular tension, or for increasing circulation and energy flow. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure/cupping suction level may be adjusted to my level of comfort. I confirm that I was given a chance to review the explanation of cupping therapy including its side effects, and that the cupping therapy practitioner has explained the possibility of cupping marks that can occur from the cupping site.

I further understand that massage/bodywork or cupping should not be construed as a substitute for medical examination, diagnosis, or treatment and that I am responsible for seeking out the care of a physician, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork and cupping 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/ bodywork/cupping should not be received while experiencing certain medical conditions, I affirm that I have stated all 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 on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

PLEASE INDICATE THAT YOU HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE FINANCIAL POLICY AND GIVE YOUR CONSENT FOR TREATMENT AS STATED ABOVE BY SIGNING BELOW:

SIGNATURE ______________________________ DATE__________________

PRINTED NAME ____

CONSENT TO TREATMENT OF A MINOR:

By my signature below, I hereby authorize a State Certified Acupressure Therapist at Sarana Community Acupuncture to administer massage to my child or dependent, as they deem necessary.

Guardian's Signature ______________________________ Date________________

Guardian's Printed Name ____