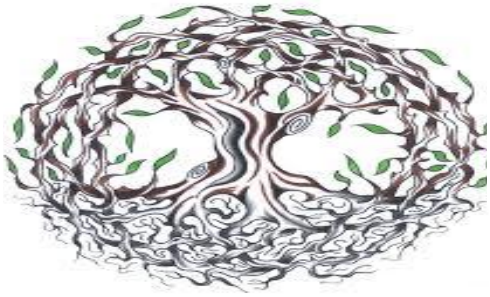
**Lauren Barry, LMT**
**314-205-0064**



**929 Fee Fee Road, Suite 100**
**Maryland Heights, MO 63043**

# What is Your Therapy Style?

We like to tailor each and every session to our clients' desires. Our clients' tastes vary and we want to make sure that during each and every visit all aspects of your session are perfect. Your therapy environment plays an important role in your results. We will keep your preferences on file for future reference. Please let us know if your preferences change.

**Check all that apply:**

**Music:**
- ❑ Play music during my session.
- ❑ No music, please.

**Temperature:**
- ❑ Table warmer on.
- ❑ Table warmer off.

**Massage Table:**
- ❑ Sheets only.
- ❑ I would like a blanket and sheets.

**Discussion:**
- ❑ I enjoy talking during my session.
- ❑ Light discussion only.
- ❑ No talking unless necessary, please.

**Massage Only:**

**Massage Therapy:**
- ❑ Full Body
- ❑ Focused work for corrective purposes

**Areas of body you *NEVER* want massaged, if any:**

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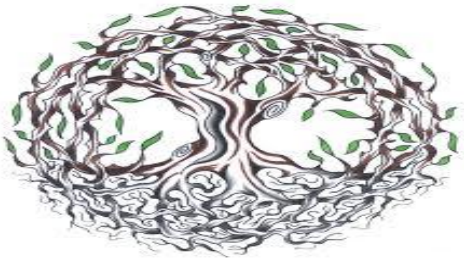
Please let us know if you have any other requests.

MOST OF ALL, ENJOY YOUR THERAPY SESSION!!!

Confidential Client Information



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Last Name _____First_____Birth Date_____

Street _____

City_____ State_____ Zip_____

Phones: Home_____Cell_____Email_____

Send me Promotions via Text Email Appointment Reminders via Text Email

Place of business/type of work _____

**Today's Visit:** How did you hear about us?_____

What type of therapy are you here for?_____ Purpose_____

Have you ever received this type of therapy before? Yes No Frequency_____

**Health Status** (check all that apply)

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis
( ) phlebitis
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) Fibromyalgia
( ) back/neck problems
( ) carpal tunnel syndrome
( ) TMJ
( ) deep vein thrombosis/blood clots
( ) tennis elbow
( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) pregnancy If yes, how many months? _____ ( ) other_____

I understand that the therapy session 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 therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that therapy session 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 therapist is 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 therapy sessions should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

**Signature**_____ **Date**_____

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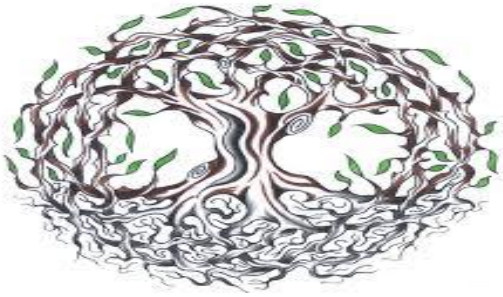

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## Cancelled and Missed Massage Appointments

Please understand that your time commitment begins at the moment you reserve a massage. In order to make it fair for everyone, please consider your schedule carefully and don't commit to a time that you feel may be questionable. There may be times when a cancellation is, of course, necessary; please provide 24~ hour advance notice when possible. There will be a charge of $40.00 for missed or cancelled appointments (medical emergencies excluded) without 24-hour notice.

I have read and understand the above policy.

Signature: _____ Date:_____

## Social Media Access

By Checking the social media below, I authorize Hands-On Therapies to add me as a "friend"/"Follower" in order to receive specials and updates about the company

- ❑ Facebook_____
- ❑ Twitter(@_____)
- ❑ Other_____

Signature: _____ Date:_____