2425- A Mahan Drive
Tallahassee, FL 32308
Phone (850) 386-8282

Welcome to Pathway Wellness

Name_____ DOB_____
(Last) (First) (Middle)

Address_____
(Street or P.O. Box)

_____
(City) (State) (Zip)

Cell Phone _____ **Do you prefer reminders via Email _____or Text Message_____?**

Email _____

Primary reason for your massage today _____

I understand that this is a massage appointment only and not intended to diagnose any specific condition, in addition I understand that this does not constitute a consultation with Dr. Farrah, DC.
I understand that my massage therapist will be working independent of Dr. Farrah, DC and cannot diagnose under FL health care laws.

Who is your Primary Care Physician? _____

Medications you are taking _____

How did you find out about our clinic? _____

Please help us ensure a safe and comfortable massage experience by answering the following with a Y or N

_____Blood Clots	_____High/Low Blood Pressure	_____Osteoporosis
_____Diabetes	_____Immune System Deficiencies	_____Rheumatoid Arthritis
_____Fibromyalgia/Lupus	_____Infections	_____Thyroid Issues
_____Headaches	_____Insomnia	_____Varicose Veins
_____Heart Problems	_____Osteoarthritis	_____Cancer
_____ History of Strokes	_____ Pain (joint, muscle, disc, nerve)	

Explanation(s) _____

Allergies (scents, nuts, etc.) _____ Sensitive to heat? _____ Pregnant? _____

Skin conditions (bruises, rashes, acne?) _____

Are you comfortable with having therapeutic massage on the following areas? YES or NO

Gluteal Region:_____ Abdomen:_____ Pectoral Muscles:_____ Feet:_____ Face/head:_____

Modest draping will be used during the session. If during the session you feel uncomfortable, simply ask your therapist to end the session. It is your responsibility to inform the therapist of any pre-existing conditions, limitations, or specific sensitivities and to inform your therapist if you feel any discomfort during the session. If you do experience discomfort, please ask the therapist to adjust the level of pressure or heat. You understand and voluntarily accept any risks of which you have been advised about associated with your massage.
This agreement is between the above cited patient and Pathway Wellness Chiropractic Clinic. The purpose of this agreement is to enable patient to receive the benefit of massage therapy at the clinic without restriction of financial hardship. The clinic has informed me of their usual fee for massage therapy ($47 per unit). Patient agrees that the financial issue(s) are not with the amount of charges or the unitization of services. To enable patient to receive the chiropractic services or massage therapy recommended clinic has agreed to offer patient a time of service discount in lieu of 3rd party billing. The charge is $65.00 is for a 1 hour massage and $35.00 for ½ hour of massage therapy. I understand that in consideration for this special financial agreement I will be expected to pay my account at the time of service.

Signature _____ Date _____