

Neighborhood
Acupuncture & Healing Arts, LLC
12582 South Fort Street
Draper, UT, 84020
P:801-662-8610

This is a CONFIDENTIAL questionnaire to help us determine the best class plan for you. Please fill it out as completely as possible. Thank you.

General Information

Today's Date ____/____/____

Full Name: _____

Date of Birth ____/____/____ Gender: M F

Mailing Address _____

City _____ State _____ Zip _____

Phone _____ E-mail _____

Occupation _____

Would you prefer to receive notifications and reminders via Email Text *Mobile provider _____

Are you interested in receiving our email newsletters? Yes No

Person responsible for your account _____ Relationship: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone Number: _____

Whom should we thank for referring you? _____

Have you had a professional massage before? Yes No If so, where?

Are you interested in additional health services besides massage therapy? Yes No

Please check all services you are interested in:

- Yoga Lessons Relaxation techniques Chinese Herbs Acupuncture Nutrition Body Work

What are your primary reasons for receiving massage?

1: _____ 2: _____

Do you have any health concerns that your massage therapist should be aware of: _____

Do you currently experience any symptoms that might interfere with your ability to receive massage?

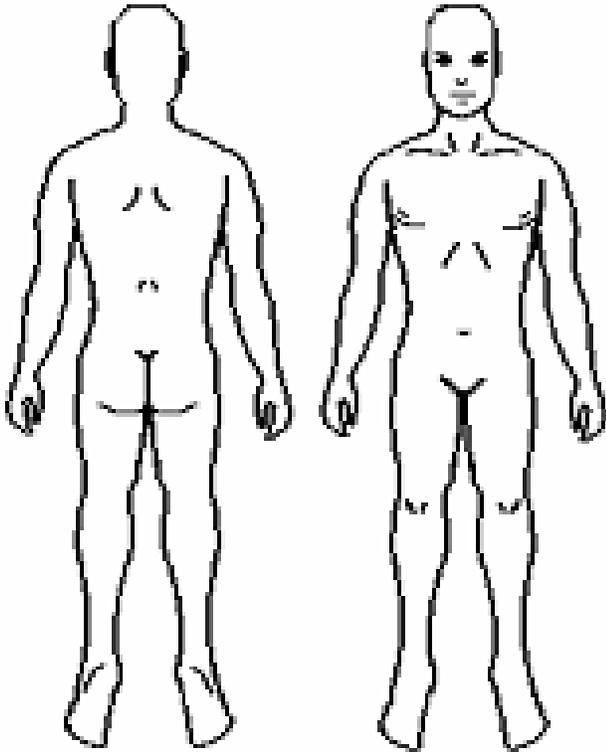
Regular or severe pain _____ Limited Range of Motion _____

Recent injury or surgery _____ Difficulty laying on stomach, back or side _____

Please mark any area's that you have pain or discomfort at least 1 time per month.

Please answer the following questions for each area that you have marked:

0: no discomfort. 1-3: I get my responsibilities done and can still have some fun. 4-6: I get my work done but refrain from recreational activities.
7-9: I'm struggling with getting my responsibilities done. 10: I am disabled either permanently or temporarily from the discomfort.
Left Right Right Left



When did the discomfort originally begin?

What were the circumstances?

How often do you experience the discomfort?

How long does it last?

What is the character of the discomfort?

What treatments have you tried to treat the discomfort?

What treatments or what conditions relieve the pain?

What situations aggravate the pain?

What is the lowest level of discomfort you have?

When is the discomfort the lowest?

How long does it last?

What is the highest level of discomfort you have?

When is it the worst?

How long does it last?

What is your average level of discomfort?

Is there anything else that you feel we should know which is relevant to your condition(s)?

Massage Liability Waiver

Informed Consent: I agree to provide complete and accurate health information and notice of health changes at successive appointments as appropriate. Because massage therapy should not be performed under certain circumstances, I agree to inform the therapist of any changes in my health history and I release the massage therapist from any liability if I fail to do so.

I understand that massage therapy is designed to be an ancillary health aid and is not suitable for primary medical treatment. The massage therapist does not diagnose illness or disease, perform spinal manipulations, prescribe medical treatments, and I understand that nothing said or done during the session should be construed as such. Massage therapy will be given as agreed upon by therapist and client for the predetermined goals of stress reduction, relief of muscular discomfort, and/or health promotion.

I will immediately inform my massage practitioner of any unusual sensation or discomfort so that the pressure or methods may be adjusted to my level of comfort.

I understand that the massage is not sexually oriented in any way and that any illicit or suggestive remarks or behavior on my part will result in immediate termination of the session.

I understand that a single massage session or massage used on a random basis is limited to providing a general, nonspecific approach using standard massage methods and does not include any methods to address soft tissue structure or function specifically.

I understand appropriate arrival times, cancellation and no show policies. I understand the fees associated with late cancellations and no showing my appointments. I understand all package terms and conditions as well as refund policies. I understand that these fees and policies may change at any time.

Release of Liability: I agree that neither myself, my heirs, assigns, or legal representatives will sue or make any other claims of any kind whatsoever against Neighborhood Acupuncture and Healing Arts Center, its staff or its members for any personal injury, property damage/loss or wrongful death, whether caused by negligence or otherwise. I understand that Neighborhood Acupuncture and Healing Arts Center reserves the right to refuse services to anyone for any reason.

This is the entire agreement between Neighborhood Acupuncture and Healing Arts Center and myself. No other agreement exists and it may be changed only if the change is in writing and is signed by both parties. I agree that this Release of Liability is intended to be as broad and inclusive as permitted by law. Any provision found to be invalid or unenforceable by a court shall not affect the validity or enforceability of any other provision. I have read this document carefully and I fully understand it. I recognize that by signing this document I am waiving certain legal rights, including the right to sue. I am signing this document voluntarily.

Participant signature: _____ Date: _____

Print Name: _____

If the participant is under the age of 18 years:

As legal guardian of (print name) _____ I consent to stated conditions and terms.

Signature of parent / guardian : _____

Arrival Time:

I understand that I must plan to arrive 10 minutes early for my appointment to allow time for checking in, using the restroom, filling out medical history forms and getting settled. _____

I understand that if I am running late, my appointment may still have to end on time, so as not to delay the next guest. _____

I understand that appointments cut short due to late arrival are payable in full. _____

I understand that the teachers and therapists are scheduled to arrive 15 minutes prior to their classes and appointments, and that if I am more than 15 minutes early the clinic may not be open yet for treatments. _____

I understand that if I arrive early and the clinic is open, naahac cannot guarantee that I will be seen before my scheduled appointment time. _____

Cancellation Policy:

I understand that cancellations can be made within 3 hours of my appointment without charge. _____

I understand that I can cancel either through the online scheduling system or by phone. _____

I understand that cancelling with less than 3 hours notice will incur a fee of \$15 and may be cancelled by calling or texting 801-662-8610 _____

I understand that exceptions to the cancellation policy will be made for sudden injury and contagious illness on a case by case basis and will be determined by Neighborhood Acupuncture and Healing Arts, LLC. _____

No-Show Policy:

I understand that if I either forget or consciously choose to forgo my appointment for whatever reason I will be considered a "no-show". _____

I understand that if I no show an appointment, I will be required to prepay for all future services at Neighborhood Acupuncture & Healing Arts. _____

I understand that any fees for late cancellations or failure to cancel an appointment will be charged to my account and will need to be paid before my next service or class. _____

I understand that future service will be denied until all fees are paid in full. _____

I understand that the only exception to this policy is emergency room visits that occur during the same time as my appointment and proof of the visit must be rendered to reverse this fee. _____

Return/Refund Policy:

I understand that refunds will be given for any prepaid unused treatments with a written request. _____

I understand that if a refund on a package is requested or if a package expires the full price for each service rendered will be deducted and any remaining balance will be refunded either to my account or in the manor that I paid for my package. _____

I understand that if a refund is requested for an auto pay contract before the contract has expired the full priced amount for any service rendered up to the amount of the package will be deducted and an additional \$50 fee will be charged for breaking the contract. Any remaining balance will be refunded. _____

I understand that with breaking an auto pay contract, if I have used the full amount of the contract price, I will be additionally responsible for the \$50 fee. _____

I understand that if a refund is given for a package or contract, I may no longer be eligible for future purchases of discounted services. All future services will be paid at the time of service for the full price of the service. _____

I understand that refunds given to a credit or debit card may take up to 30 days to be returned on the card. _____

Purchase Policy

I understand that cash, personal checks and Visa, Master Card, American Express, and Discover are accepted for services and any product purchases at Neighborhood Acupuncture & Healing Arts. _____

I understand that payment is due at the time services and/or products are received. _____

I understand that a \$25.00 fee will be applied to all dishonored payments (returned checks or credit card payments). _____

I understand that all prices are subject to change. _____

I understand that gratuity is not included in the service price nor am I required to tip my therapist (but the generosity is greatly appreciated). _____

Packages and Contracts

I understand that 5 packs offer a 5% discount and this promotional value will expire 12 months from the time of purchase. _____

I understand that 10 packs offer a 10% discount and this promotional value will expire 12 months from the time of purchase. _____

I understand that 20 Packs offer a 20% discount and this promotional value will expire 12 months from the time of purchase. _____

I understand that numbered packages may be shared between friends and family members. _____

I understand that unlimited packages are non-transferable. _____

I understand that Auto-pay contracts may be paused once per year for up to 6 months with a 30 day written notification. _____

I understand that to break a contract before the allotted payments will incur a \$50 fee. _____

Massage Treatments

We work very hard to make sure that each client receives personalized attention and is made as comfortable as possible during their treatments. This requires an open communication between the client and the practitioner. _____

I understand that if I ever have something to communicate with my practitioner that I would prefer to talk about in private, I will need to ask to speak to my practitioner before my treatment in the consultation room. _____

I understand that it is my responsibility to inform my practitioner of any changes in my health or any new treatments I am receiving before my treatment or class. _____

I understand that Neighborhood Acupuncture and Healing Arts reserves the right to refuse services to anyone at any time or end a session with a client who is not respectful, or makes any unwanted comments or advances to the practitioners, other clients, or any other person on the premises. _____

I understand that for my safety, Neighborhood Acupuncture & Healing Arts will not allow any person to receive treatments or to attend classes if they are intoxicated. _____