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— w e l l n e s s —

We would like to welcome you to DREAM Wellness and thank you for purchasing your promotional certificate!

We look forward to providing you with an exceptional massage and wellness experience and hope you return for future services and tell your friends (and let everyone on Yelp and Google know too!).

**Please be generous and take great care of your massage therapist! Our therapists run these promotions to help provide the community with a great service and to build their businesses. The average gratuity is \$20* (especially with these great offers because sometimes your gratuity is all they receive) so please be kind and help put a smile on her face, especially if she put one on yours!

*EliVeLife certificates require a \$20 minimum gratuity

In case you are not aware, your certificate also comes with a complimentary wellness assessment. The assessment helps the massage therapist pin point areas that are not functioning optimally (regardless of how you feel) that may be causing unnecessary pulling and strain on your body. The scan also gives insight into your general health and wellbeing. Even if you didn't have the opportunity to receive your assessment prior to this massage, you are welcome to schedule a scan for a future time, at no charge. Just let the receptionist or massage therapist know and either will gladly help you!

Name: _____ DOB: _____ Occupation: _____

Address _____ City _____ Zip _____

Phone: _____ E-mail _____

Emergency Contact: _____

For appointment reminders, is it ok to text your cell phone? Y / N If yes, cell carrier: _____

Goal for today's massage: _____

Who may we thank for referring you to our center? _____ How long since last massage? _____

What type of wellness providers have you been to before? (Make a check mark ✓ if in past, circle X if current)

- Chiropractor Massage Therapist Nutritionist Acupuncturist Personal Trainer/Fitness Expert
 MAT Specialist Life Coach ? Other _____

Do you currently have any of the following health challenges:

- Pain/tension Neck/Upper Back Pain Vertigo/ Dizziness Allergies Low Back Pain
 Frequent Colds Sinus Congestion ADD / Concentration issues Headaches / Migraines
 Digestive Trouble Skin Issues Foot Pain Other _____

Current Medications _____ Surgeries I have had in the past _____

WOMEN: Are you pregnant? Y/N If yes, when are you due? _____

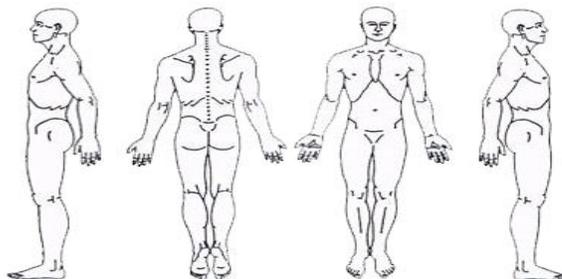
If you currently have any of the symptoms listed above, how long have you had them? _____

How important is it to YOU that the cause gets resolved? Very Moderately Not at all

Have you ever had a digital nerve scan and wellness assessment? Yes/No/Scheduled

By Whom? _____ Approximate date: _____ Result: _____

Please indicate on the figures where you generally have pain or discomfort, if applicable, even if it does not hurt today. Additionally, please draw any areas of broken bones, surgeries or other significant injuries to the body and write the approximate year next to it.



Massage is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch to promote overall body wellness. The general benefits of massage, possible massage contraindications and the care procedures have been explained to me. I understand that massage is not a substitute for medical treatment, and it is recommended that I concurrently work with a primary caregiver for any conditions I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications and that spinal adjustments are not part of massage. I have or will inform the massage therapist of all my known physical conditions, past surgeries and medications currently taking and I will keep my massage therapist updated on any changes.

Any inappropriate comments, advances or gestures made towards the massage therapists or any provider will not be tolerated and will be asked to leave the premises immediately.

I, _____ (print name) have read and fully understand the above statements.

All questions regarding the caregiver's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept massage on this basis.

Signature _____

Date _____



24 HOUR CANCELLATION POLICY

This form is to advise you of our office's 24 hour cancellation policy. Due to the overwhelming demand and limited appointment slots, we are unable to hold an appointment time for you if you are not able to keep it. Giving us notice of 24 hours or more allows us to fill the appointment time slot from the waiting list of others needing an appointment.

If you need to cancel your scheduled appointment, please notify us as soon as possible, at the very latest 24 hours prior to your scheduled appointment. If you cancel an appointment with less than 24 hours notice, you will be charged the full fee for the appointment you were scheduled for. (If you are scheduled for a service from a package previously purchased, you will lose that visit.)

By signing below, you acknowledge the above and fully understand the cancellation policy.

Signature

Printed Name

Date

Credit Card # _____ Exp date _____ CID _____
Only last 4 numbers if we have it on file

Zip Code _____