

Cosmetic Plastic Surgery Institute  
Joseph E. Berg, M.D.

## Massage Patient Medical Information

Date	Patient Name: Last	First	MI	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced
Street Address		City	State	Zip Code
Home Phone # ( )	Work Phone # ( )	Birth Date	Age	Social Security
Race	Sex	Occupation (Indicate if Student)	Employer	
Employer Address (include City and State)		Referred By: <input type="checkbox"/> Friend <input type="checkbox"/> Other <input type="checkbox"/> Phone Book E-Mail Address:		

Leisure time activity(sports, hobbies, outside work) \_\_\_\_\_

Your general condition of health \_\_\_\_\_

Have you had any serious illness? \_\_\_\_\_

Have you had any operations? \_\_\_\_\_ if so please list \_\_\_\_\_

Have you had any traumatic accidents or broken bones? \_\_\_\_\_

Are you on any medication? \_\_\_\_\_

Do you use supplements? \_\_\_\_\_

Do you wear contacts? \_\_\_\_\_

Are you currently being treated by a doctor or chiropractor? \_\_\_\_\_

If yes for what conditions \_\_\_\_\_

Have you received a massage before? \_\_\_\_\_

What is your expectation for this massage? \_\_\_\_\_

**\*ALL INFORMATION PROVIDED ON THIS FORM IS STRICTLY CONFIDENTIAL**

Information exchanges during an silklight or massage session is educational in nature and intended to help you become more familiar and conscious of your own health status, and is to be used at your own discretion. I understand that the silklight or massage services are designed to be a health aid and are in no way to take the place of a doctor's care when it is indicated. I also understand that I have a choice of silklight or massage pressure and although not the standard, I can wear my under garments if I desire and can have the therapist avoid any areas at my discretion. This signature shall be valid for all of my visits for silklight or massage treatments, and any concerns will be my responsibility to handle with the therapist and not the Cosmetic Plastic Surgery Institute. CPSI and Dr. Berg will not be involved or responsible for any concerns or claims.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



A massage can be very relaxing and therapeutic, however your individual preferences are crucial in allowing the therapist to deliver the most beneficial massage possible, so please speak up at any point in the massage if something is not comfortable, pressure too soft, too firm, or if an area needs to be avoided. Answering the following questions will also help up to know how to approach your massage.

Please check the best response

1. How do you like your pressure?  Deep  Medium-Firm  
 Medium-Light  Medium  
 Light
2. Do you have any areas that are injured, sore or need special attention? Please be certain the therapist is aware.

---

---

3. Please check whether you want the areas below included in your massage
- |                     |                              |                             |   |
|---------------------|------------------------------|-----------------------------|---|
| Abdomen muscles     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes but while covered with a sheet |
| Gluteus muscles     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes but while covered with a sheet |
| Chest muscles       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes but while covered with a sheet |
| Inner thigh muscles | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes but while covered with a sheet |

Are there any other areas that you are uncomfortable having massaged? Please list below:

---

---

4. Are there any areas you want or need extra time and attention?

---

---

Most people do not wear underwear because you will be covered with a sheet, however if you prefer, you can wear your underwear bottoms (this is not standard due to the cover linens).

It is very critical that you feel comfortable and relaxed. Let us know if anything is preventing your complete relaxation during your massage. We would like to create the best possible experience for you.

Thank you for choosing the Cosmetic Plastic Surgery Institute and Day Spa. We hope you enjoy your experience.



If you are 15 minutes or more late to an appointment, you will need to reschedule for another time, this is to ensure all of our clients can be seen in a timely manner. All clients should call 24 hours before their appointment if they need to cancel. If you are unable or forget to call 24 hours in advance you will forfeit one treatment of your package, your booking fee or part of your gift certificate. Thank you for your awareness of our policy. We appreciate your visit and hope you enjoy your time at our Day Spa.

I, \_\_\_\_\_ (please print) have read and agree to the above policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**PRIVACY PRACTICES ACKNOWLEDGEMENT**

**Cosmetic Plastic Surgery Institute and Day Spa**

498 E 800 N – Stratford Park – Orem, Utah 84097

**ACKNOWLEDGEMENT FORM**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**I wish Dr. Berg or his staff to share information with:** \_\_\_\_\_.

**Relationship:** \_\_\_\_\_.

**I give my permission to confirm appointments by:**

Message on answering machine YES NO

Message with family member YES NO

Message with anyone answering YES NO

**Name of Patient (Print)** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Signature of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_