

Client Information

Name: _____

Telephone: _____

Address: _____

Birth Date: _____

Referred by: _____

Telephone: _____

Emergency
Contact: _____

Telephone: _____

General & Medical Information

Age: _____ Sex: _____

Have you ever experienced a professional massage or bodywork session? Yes No
If Yes, How recently? _____

If you answer "Yes" to any of the following questions, please explain as clearly as possible.

- ◇Yes ◇No Do you frequently suffer from stress?
- ◇Yes ◇No Do you have diabetes?
- ◇Yes ◇No Do you experience frequent headaches?
- ◇Yes ◇No Are you pregnant?
- ◇Yes ◇No Do you suffer from arthritis?
- ◇Yes ◇No Are you wearing contact lenses?
- ◇Yes ◇No Do you have high blood pressure?
- ◇Yes ◇No - If "Yes" are you taking medication for it?
- ◇Yes ◇No Do you suffer from epilepsy or seizures?
- ◇Yes ◇No Do you suffer from joint swelling?
- ◇Yes ◇No Do you have varicose veins?
- ◇Yes ◇No Have you ever had surgery?
- ◇Yes ◇No Do you have any contagious disease?
- ◇Yes ◇No Do you have osteoporosis?
- ◇Yes ◇No Do you have any allergies to fragrances?
- ◇Yes ◇No Do you bruise easily?
- ◇Yes ◇No Have you had any broken bones in the last two years?
- ◇Yes ◇No Have you been in an accident or suffered any injuries in the past two years?
- ◇Yes ◇No Do you have tension or soreness in a specific area?
- ◇Yes ◇No Do you have cardiac or circulatory problems?

- ◇Yes ◇No Do you suffer from back pain?
- ◇Yes ◇No Do you have numbness or stabbing pains anywhere?
- ◇Yes ◇No Are you very sensitive to touch or pressure in any area?
- ◇Yes ◇No Do you have any other medical condition I should be aware of?

Comments: _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief from muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to a better level of comfort. I further understand that massage or bodywork 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 massage/bodywork practitioners are 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 massage/bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall be No liability on the practitioner's part should I forget to Do so. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature _____ **Date** _____

Practitioner Signature _____ **Date** _____

If you'd like to receive email updates on specials and new therapies please include your email address here.

This is for my use only and will not be sold or shared with any other businesses.