MASSAGE THERAPY ~ CLIENT INFORMATION

Personal Information:

Name _____ D.O.B._____

Address:_____

City:_____ State:_____ Zip:_____

Email Address_____

Home Phone: (_____)_____ Okay to leave voicemail? Yes No

Cell Phone: (_____)_____ Okay to leave voicemail? Yes No

Okay to text? Yes No

Would you like to receive updates on special offers via email or snail mail? Yes No

What is your preferred method of contact? _____

Occupation:_____

Emergency Contact:_____ Phone:(_____)_____

If there is anyone who is allowed to take messages on your behalf or schedule appointments on your behalf, please list those people _____

The following information will be used to plan safe and effective massage sessions so please answer to the best of your knowledge:

Have you ever received professional massage before: Yes No

If yes, how often do you receive massage & when was your last session?_____

What type of pressure do you prefer: Light Medium Firm

Do you have difficulty laying on your front, back, or side? Yes No

Do you have any allergies to food, oils, lotions, etc.? Yes No

If yes, please list _____

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

If yes where?_____

What are your goals for our session today? _____

If there are any areas you do not want worked on today, please list. _____

Circle any of the following you normally wear. Contact Lenses Dentures Hearing Aid

On a scale of 1-10, how stressed are you? _____

Medical HIstory:

Are you currently under medical supervision? Yes No

If yes, please explain_____

_____

Are you currently taking any medications, herbs, or supplements? Yes No

If yes, please list _____

_____

Please check any condition that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent injury or accident
( ) recent fracture
( ) broken bones
( ) recent surgery
( ) artificial joint
( ) allergies/sensitivity
( ) heart condition
( ) back pain
( ) varicose veins
( ) joint disorder/arthritis/tendonitis
( ) deep vein thrombosis/blood clots
( ) osteoporosis
( ) epilepsy or seizure disorder
( ) headaches or migraines
( ) sensitivity to touch or pressure
( ) cancer
( ) diabetes
( ) high/low blood pressure
( ) circulatory disorder
( ) numbness or stabbing pain
( ) pregnancy If yes, how many months? ____

Is there anything else about your health history you feel would be important for your massage therapist to know in order to plan a safe and effective massage for you? _____

_____

_____

Draping will be used during the session and only the area being worked on will be uncovered. Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 18.

I,_____ (PRINT NAME) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 therapists 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 should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. Iagree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. **I also understand that any illicit or sexual 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.**

Signature of client: _____ Date:_____

Signature of Massage Therapist: _____ Date:_____

Consent to treatment of minor: By my signature below, I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian: _____ Date _____