Contact Information

Name_____Date_____

Address_____City_____State_____Zip_____

E-Mail_____Primary Ph.#_____Secondary Ph.#_____

Occupation_____ Date of Birth_____

Emergency Contact Person_____Phone_____

Who may I thank for referring you?_____

Health Information

In order to plan a safe and effective massage session, please answer the following thoroughly and to the best of your knowledge. All information will be held in the highest confidence.

Please mark an (X) by all current conditions and (P) for all past conditions

__Allergies
__Asthma
__Arthritis
__Athletes Foot
__Blood Clots
__Blood Pressure (high / low)
__Broken Bone(s)
__Cancer / Tumor
__Car / Other accident
__Carpal Tunnel
__Cortisone Injection(s)
__Cysts
__Disorders of the Spine
__Diabetes
__ Endometriosis
__ Fibromyalgia
__ Headaches
__ Heart Condition
__ Hernia
__ Hemophilia
__ Hepatitis
__ Herpes
__ Hypo / Hyper Thyroidism
__ Impetigo
__ Insomnia
__ Intestinal Disorder
__ Jaw / TMJ Pain
__ Kidney Disorder
__ Lupus
__ Migraines
__ Mononucleosis
__ Multiple Sclerosis
__ Neuropathy / Numbness
__ Osteoporosis
__ Parkinsons Disease
__ Seizures
__ Skin Conditions
__ Sprains / Strains
__ Surgery
__ Tendonitis
__ Tuberculosis
__ Uterine Fibroids
__ Varicose Veins

Elaborate on noted areas above:_____

_____

Are you pregnant? Yes No If yes, when is your due date? _____

Are you currently under a doctor's care? Yes No If yes, what is the diagnosis or treatment?

_____

Current herbs and / or medications _____

Are you wearing: contact lenses [ ] dentures [ ] a hearing aid [ ] ?

Do you have sensitive skin? Yes No

Do you have any allergies or aversions to scents, oils, lotions, or ointments? Yes No
If yes, please explain_____

Do you have any conditions that may be spread through massage? Yes No If yes, please explain

_____

Do you have any open cuts, scrapes, wounds or bleeding cuticles? Yes No

Have you received a professional massage before today? Yes No
If yes, how often do you receive massage therapy?_____

Do you sit for long hours at a workstation, computer or driving? Yes No
If yes, please describe_____

Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please describe_____

Do you experience stress in your work, family or other aspect of your life? Yes No
If yes, how do you think this has affected your health?
muscle tension [ ] anxiety [ ] insomnia [ ] irritability [ ] other_____

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?

_____

What are your goals and expectations for receiving massage? _____

_____

Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage for you?:_____

_____

Draping will be used during your massage session - only the area being worked on will be uncovered.

Please take a moment and carefully read the following information:

*Because massage should not be performed under certain medical conditions, I have stated all my known conditions, and this information is true and accurate to the best of my knowledge. I understand that the massage I receive is for the purpose of relaxation and relief of muscular tension. I****f I experience any pain or discomfort, I will immediately inform my massage therapist so that the pressure and/or methods can be adjusted to my comfort level****. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see my primary care practitioner 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 in the course of the session should be construed as such.*

I understand that I am receiving massage therapy at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, there shall be no liability on the therapists part.

24 hours notice is requested for any cancellations to avoid being charged for your visit.

Client Signature: _____ *Date:*_____