

Client Information

Name: _____ Preferred Phone: () _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Email: _____

In case of emergency: _____ Phone: () _____

How did you hear about this office? _____ Preferred form of communication _____

Massage music preference: Classical New Age/Meditative Instrumental (piano, guitar) Other _____

General & Medical Information: Age: _____ Male Female

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

What type of pressure do you like? Light Medium Deep Unsure

If you answer "yes" to any of the following questions, please explain as clearly as possible in comments section below.

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?

If Yes, Where? _____

Yes No Do you have high blood pressure?

Yes No If "yes" to previous question, are you taking medication for this?

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?

Yes No Do you bruise easily?

Yes No Have you ever had any broken bones?

Yes No Have you ever been in an accident or suffered any serious injuries?

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: _____

Are there any areas you **DO NOT** want me to work on? **No** **Yes** If so, indicate where _____

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 of 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 my 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 _____

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 _____