Massage Client Information

Name: _____ Date of Birth_____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

E-mail:_____ Occupation: _____

Emergency Contact Person: _____ Phone: _____

Are you currently under a physician's care for an acute or chronic illness? Y_____ N_____

Please explain _____

If yes, who is your health care provider: _____?

Are you currently taking any prescribed medication or dietary supplements? Y ____ N ____

If yes please explain: _____

Have you received a massage before? Y____ N____ If yes, what did you like or dislike?

_____

How did you hear about us? _____

What are your goals for this session? _____

Please list areas of tension you would like me to address as well and/or areas you would like me to avoid

_____

Are you allergic or sensitive to any oils(essential oils, nut oils, or scents)?

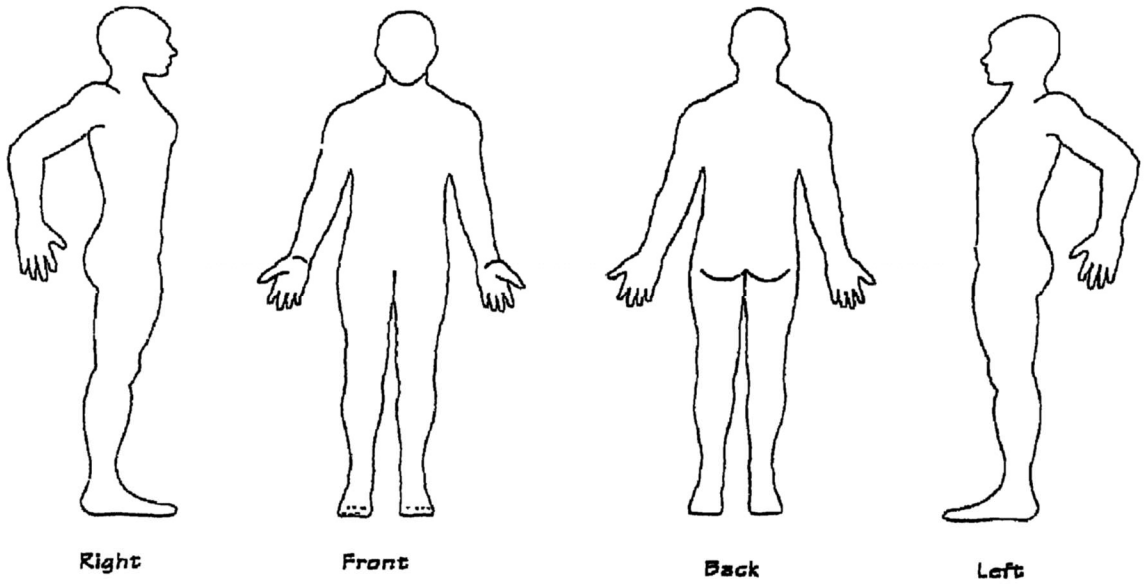
_____

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

___Cancer : Type___	___Hi/Low Blood Pressure	___TMJ
___Migraines/Headaches	___Immovable Joints	___Tendonitis/Tendinosis
___Back Problems	___Cold Hands/Feet	___Bruise Easily
___Sciatica	___Sinus Problems	___Allergies
___Arthritis/Bursitis/Joint	___Neck Problems	___Fibromyalgia
___Diabetes	___Recent Surgery	___Varicose Veins
___Carpal Tunnel Syndrome	___Recent Accident	___Contagious Skin Condition

___Pregnancy If yes, How many months?_____

Please indicate with an (X), if any, the areas in which you are feeling discomfort.



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

_____

_____

I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I will inform my health care provider and massage therapist if anything changes in my status. I understand that massage/bodywork I receive is for the purpose of stress reduction and the relief from muscular tension, spasm or pain and to increase circulation. If 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 understand that my massage therapist does not diagnose illness or disease, nor perform any spinal manipulations, and does not prescribe any medications/treatments. I acknowledge that massage is not a substitute for a medical examination or diagnosis and that I should see my health care provider for those services. If I am unable to attend my scheduled appointment, I will respect and abide by the set cancellation policies. Sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated. 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, of the aforesaid massage therapy I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.

Client Signature: _____ *Date*_____

24 Hour cancellation policy: Any appointment not cancelled within 24 hours of the appointment time is subject to a $50 cancellation fee.

Signature_____ Date _____