



Massage Therapy CLIENT INFORMATION please print clearly

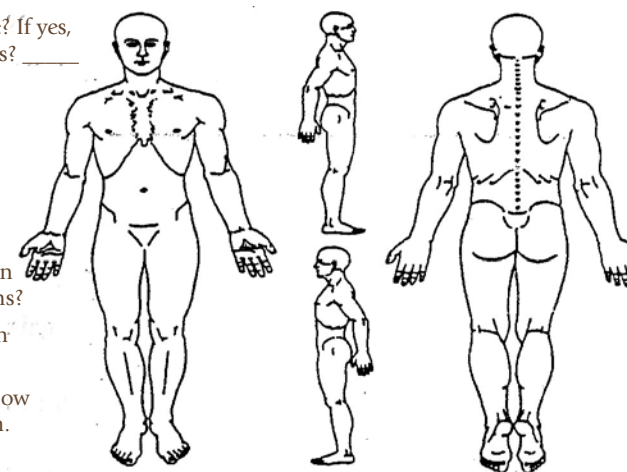
Name: _____ Phone: (____) _____ Work Phone: (____) _____
 Address: _____ City: _____ State: _____ Zip: _____ Date of Birth: _____
 Email: _____ Referred by: _____
 In case of emergency: _____ Relationship: _____ Telephone: _____

General & Medical Information (Please explain **YES** answers in **COMMENTS** section below.)

Please draw the areas of your pain or symptoms

Yes No Have you had massage therapy before?
Yes No Do you frequently suffer from stress?
Yes No Do you experience frequent headaches?
Yes No Have you had any broken bones in the last 2 years?
Yes No Have you had surgery recently?
Yes No Do you have soreness or tension in a specific area? Please explain below.
Yes No Do you bruise easily?
Yes No Are you sensitive to pressure/touch in any areas?
Yes No Do you have numbness or stabbing pains?
Yes No Are you allergic to Aspirin or flower essences?

Yes No Do you have high blood pressure? If yes, are you taking medication for this? _____
Yes No Do you have back pain?
Yes No Are you pregnant?
Yes No Are you wearing contact lens?
Yes No Are you diabetic?
Yes No Are you epileptic?
Yes No Do you experience dizziness when turning over or changing positions?
Yes No Would you like more information about our wellness center?
Yes No Is there anything else I should know about your health? Please explain.



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 rendered.

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 the session, I will immediately inform the practitioner so that the pressure and/or stroke may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware, 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 should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all y 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. I also understand that any illicit or sexually suggestive remarks or advances made by me the client, will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. **I am also liable as the client to pay the full amount of the session when I do not appear at my scheduled appointment time or cancel within 24 hours of scheduled appointment time.**

Client Signature: _____ Date: _____ Practitioner Signature: _____ Date: _____