Today's Date_____

Name_____Phone #_____

Occupation_____

Address_____

Email_____Date of Birth_____

Who may I thank for referring you?_____

If not a referral, how did you hear about me?_____

The following information will be used to help plan safe and effective massage sessions. It will be kept confidential. Pleaser answer to the best of your knowledge.

Have you had a professional massage before? Yes No

How recently?_____

On a scale of 1 - 10, how would you rate your pain today?_____

What makes it worse?_____

What makes it better?_____

How is your water intake?_____

How is your sleep?_____

How are your energy levels?_____

How are you doing emotionally?_____

On a scale of 1 - 10, how much pressure do you prefer?_____

Do you have any particular goals for this massage session? Yes No

If yes, please explain_____

Is there any area you would like me to spend more time on?_____

Is there any area you would like me to leave out?_____

Do you have any allergies or skin sensitivities to oils or lotions? Yes No

If so, please explain_____

Are you currently taking any medications, prescription or over-the-counter? Yes No

If yes, please list_____

Who is your Primary Care Physician?_____

Who is your Chiropractor?_____

Emergency contact?_____Phone #_____

Are you wearing:

Contact lenses? Yes No

A hearing aid? Yes No

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

Please circle any condition below that applies to you:

Anxiety	Varicose veins	Depression	High or low blood pressure
DVT/blood clots	Heart condition	Easy bruising	Circulatory issues
Artificial joint	Diabetes	Numbness	Headaches/migraines
Recent surgery	Recent injury	Pregnancy	Osteo or rheumatoid arthritis
Osteoporosis	Epilepsy/seizures	TMJ	Food allergy or sensitivity

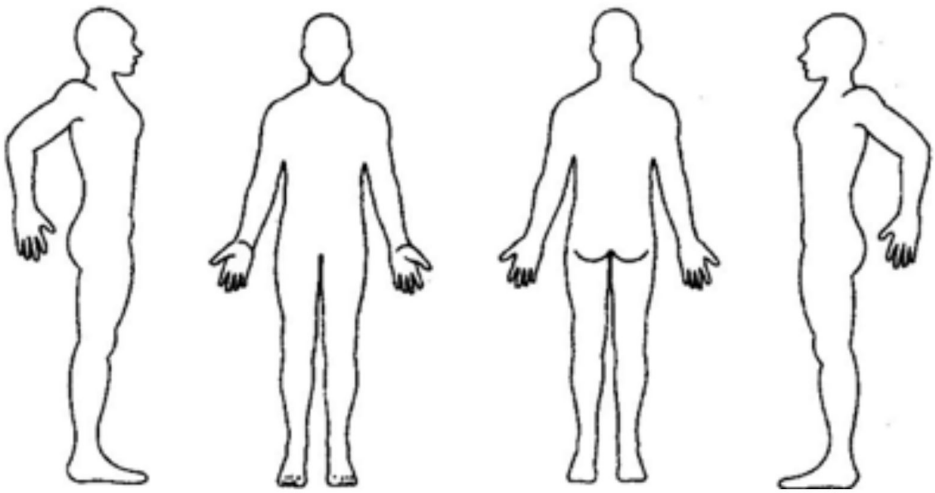
Please explain any condition you circled above:_____

_____

Is there anything else about your health history that you think would be useful for your massage therapist to know?

_____

Please circle any specific areas you would like the massage therapist to concentrate on during the session



Please answer the following questions if this is a PRENATAL MASSAGE.

How many weeks along are you?_____

My due date is_____

What number baby is this for you?_____

Who is your OB/GYN?_____

Consent for Treatment

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 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 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 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 fail to do so.

Understanding all of this, I give my consent to receive care.

Client signature_____Date_____