

**Client Information**

Name: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt#: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Fax#: \_\_\_\_\_ Email: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Referred by: \_\_\_\_\_  
 In case of emergency: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_

**General & Medical Information:**

*If you answer "yes" to any of the following questions, please explain as clearly as possible.*

- |   |   |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had professional massage?                              | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had any broken bones in the past two years?                                 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience frequent headaches?                                | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have tension or soreness in a specific area?                                  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant?  | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have cardiac or circulatory problems?   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing contact lenses?                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from back pain?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you diabetic?  | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have numbness or stabbing pains anywhere?                                     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high blood pressure?                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you very sensitive to touch / pressure in any area?                              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No If yes to the previous question, are you taking medication for this? | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? If yes, please explain in the comments area of this form. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from seizure disorders or epilepsy?                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any other medical condition that I should be aware of?                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer frequently from stress?                                |   |

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 provided.) I understand that 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 immediately inform the therapist so that the pressure and / or strokes 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 consult a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage / bodywork therapists 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapists part should I neglect 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: \_\_\_\_\_

Therapist  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Information and Suggestions for the Client**

- ◆ Prior to your massage, remove all jewelry. Pull long hair back with a clip.
- ◆ As a rule, massage is given while you are unclothed. We provide a top sheet and / or towel. Modesty and comfort levels vary from person to person. You may choose to wear undergarments or a swim suit or nothing at all. This is YOUR massage and you should feel as comfortable as possible.
- ◆ During your massage, you may want to give your therapist feedback as to pressure (deeper or lighter) or point out painful or ticklish areas of your body.
- ◆ Feel free to ask your therapist any questions about their procedure. Your therapist is a highly trained professional and will be happy to make you feel well informed and comfortable.

## Pain Chart

Circle any specific areas you would like the massage therapist to concentrate on during the session.

