CLIENT INFORMATION

Name_____Cell Phone (_____)_____DOB_____

Address_____City_____State_____ Zip_____

Email_____ Referred by _____

In case of emergency_____ Phone (_____) _____

Live here full time _____ Snowbird _____ Visiting _____

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.

□ Yes □ No Do you frequently suffer from stress?
□ Yes □ No Do you have diabetes?
□ Yes □ No Do you have a thyroid condition?
□ Yes □ No Do you experience frequent headaches?
□ Yes □ No Are you pregnant?
□ Yes □ No Do you suffer from arthritis?
□ Yes □ No Are you wearing contact lenses or dentures?
□ Yes □ No Do you have cardiac or circulatory problems?
□ Yes □ No Do you have high blood pressure and/or take medication to manage blood pressure?
□ 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 Do you have any contagious diseases?
□ Yes □ No Do you have osteoporosis?
□ Yes □ No Do you have any allergies or sensitivities (i.e. nuts, iodine, shellfish, flowers, scents)?
□ Yes □ No Do you bruise easily?
□ Yes □ No Any broken bones in the past two years?
□ Yes □ No Any injuries in the past two years?
□ Yes □ No Do you suffer from back pain/disk herniation?
□ Yes □ No Do you have numbness or stabbing pains?
□ Yes □ No Are you sensitive to touch/pressure any area?
□ Yes □ No Have you ever had surgery?
□ Yes □ No Other medical condition, or are you taking any medications?

Comments _____

_____

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

What are your goals for today's treatment? _____

What kind of pressure do you prefer? □ light □ medium □ firm _____

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 therapist so that the treatment, 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 see a physician, chiropractor, 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 during 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 therapist's part should I failto do so. I also understand 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.

CANCELLATION POLICY: For appointments cancelled within 12 hours of session time, a $40 cancellation fee will be charged. Any clients with a no show or late cancel (within 12 hours) of an appointment will be required to put a credit card on file before making another appointment. I attest to have read this policy and agree to the cancellation terms.

Client Signature_____ Date _____

Practitioner Signature_____ Date _____

Parental Signature if patient is under 18 years old _____ Date _____