CLIENT INFORMATION

Name_________________________________Cell Phone (______)_________________DOB____________

Address____City_________________State_____ Zip______

Email______________________________________ Referred by __________________________________

In case of emergency_____________________________________ Phone (______) __________________

□ Live here full time □ Snowbird □ Visiting

□ Yes □ No	Do you have diabetes?	□ Yes □ No	Do you suffer from joint swelling?
□ Yes □ No	Do you have varicose veins?	□ Yes □ No	Do you have osteoporosis?
□ Yes □ No	Do you have high blood pressure and/or take mediation to manage blood pressure?	□ Yes □ No	Do you have any allergies or sensitivities (i.e. Nuts, iodine, shellfish, flowers, scents)?
□ Yes □ No	Do you have a thyroid condition?	□ Yes □ No	Do you suffer from epilepsy or seizures?
□ Yes □ No	Do you experience frequent headaches?	□ Yes □ No	Do you bruise easily?
□ Yes □ No	Are you pregnant?	□ Yes □ No	Do you suffer from arthritis?
□ Yes □ No	Any injuries/broken bones in past 2 years?	□ Yes □ No	Do you suffer from back pain/disk herniation?
□ Yes □ No	Are you wearing contact lens or dentures?	□ Yes □ No	Do you have numbness or stabbing pains?
□ Yes □ No	Do you have cardiac or circulatory problems?	□ Yes □ No	Are you sensitive to touch/pressure in any area?
□ Yes □ No	Are you taking any medications? **If yes, list on the back of this form.**	□ Yes □ No	Have you ever had surgery? **If yes, list on the back of this form.**

Comments ____

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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 mylevel of comfort and privacy. 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 physicalor 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.

I have the right to request the reapplication of draping or to stop the session at any time if I feel uncomfortable. The adjustment of the draping will be done in a professional manner, and the therapist will only expose the area being treated.

CANCELLATION POLICY: For appointments cancelled within 12 hours of the 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 __________