Client Information

Name _____ Birthday _____ E-Mail _____

Address _____

City/State/Zip _____

Telephone (Home) _____ (Work) _____ (Cell) _____

In case of emergency (name) _____ Telephone _____

Have you ever had a massage before? _____

Are you on medication? If yes, what? _____

How did you hear about us? _____

Please check, or answer yes or no to any of the following conditions which apply to you, past or present:

_____ Dislocations
_____ Back injuries
_____ Mid-back pain
_____ Lower-back pain
_____ Neck injuries
_____ Pulled muscles
_____ Fractures
_____ Other recent bone trauma
_____ Stiff neck
_____ Do you have tension or soreness in a certain area? Please specify _____
_____
_____ Recent surgery
_____ Numbness, tingling or nerve problems
_____ Inflammations or joint swelling
_____ Auto Immune Disease
_____ Muscle cramping
_____ Arthritis
_____ Do you bruise easily?
_____ Do you have any contagious disease?
_____ Fainting spells
_____ Do you have varicose veins?
_____ Diabetes
_____ Osteoporosis
_____ Cancer
_____ Cardiac or circulatory problems?
_____ High blood pressure
_____ Headaches
_____ Nausea
_____ Epilepsy or seizures
_____ Sore arms
_____ Pregnancy
_____ Allergies
_____ Are you presently wearing contact lenses?
_____ Are you presently wearing dentures?
_____ Are you sensitive to touch or pressure in any area? Please specify _____
_____ Other conditions

If you have a specific medical condition or specific symptoms, massage may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

I understand that the massage 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 practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I farther understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. 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. 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.

Client Signature _____ Date _____

May we add you to our e-mail list for newsletters and promotional offers? Y / N

Please indicate any issues you may be having on the diagram below: