

Welcome! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions please let me know, thank you.

Client Full Name: _____ Date of Birth: _____

Address: Street _____ Apt # _____

City _____ State _____ Zip _____

Phone Number: Home _____ Cell _____

Email: _____

Referred by: _____

Emergency Contact: Full name _____ Relationship: _____

Phone Number: _____

Physician/Health Care Provider: Name _____ Phone: _____

Do you have a referral letter/prescription? Yes No

Have you ever received professional massage/bodywork before? Yes No

What type: _____ How recently: _____

What are your goals/expected outcomes from receiving massage/bodywork?

Do these symptoms interfere with your activities of daily living (sleep, exercising, work, etc.)

List medications you are currently taking, and what you are taking them for:

Please list ALL injuries/car accidents/surgeries/diseases or severe illnesses past or present:

Please review this list and check the conditions that affect your health presently or in the past:

Musculoskeletal:

- Bone/Joint Disease
- Tendonitis/Bursitis
- Arthritis/Gout
- Jaw Pain/TMJ syndrome
- Spinal Problems

Other: _____

Circulatory:

- Heart Conditions
- Phlebitis/Varicose Veins
- Blood Clots
- High/Low Blood Pressure
- Lymph Edema
- Thrombosis/Embolism

Other: _____

Respiratory:

- Breathing Difficulties/Asthma
- Emphysema
- Allergies-Specify: _____

- Sinus Problems

Other: _____

Nervous System:

- Shingles
- Numbness/Tingling
- Pinched Nerve

Other: _____

Skin:

- Athletes Foot, Hand/Plantar Warts
- Allergies – Specify:
- Rashes
- Herpes/Cold Sores

Others: _____

Reproductive:

- Pregnant-Trimester: _____
- Ovarian/Menstrual Problems
- Prostate

Other: _____

Digestive:

- IBS
- Ulcer

Other: _____

Other:

- Cancer/Tumors
- Bladder/Kidney Ailments
- Diabetes
- Chemical Dependency (alcohol, drugs, tobacco, caffeine etc): _____
- Chronic Fatigue
- Chronic Pain – Area(s): _____
- Sleep Disorders
- Migraines/Headaches
- Anxiety/Stress Syndromes
- Depression
- Contact Lenses
- Car Accident (whiplash), detail: _____

The following sometimes occurs during massage, they are normal responses to relaxation. Trust your body to express what it needs to:

- Move or change position, sighing, yawning, change in breathing, stomach gurgling, emotional feelings and/or expression, movement of intestinal gas, energy shifts, falling asleep, recalling memories, etc.

Please read the following information and sign below:

- Cancellation Policy: Please give at least 24hrs notice when canceling or re-scheduling appointments. A \$35 fee may be charged for notifying later than this. There is no charge for canceling due to emergencies.
- No-Show appointments: If you don't show up for an appointment a fee of \$35 may be charged, so please call if you can. There is no charge for a no-show due to an emergency.
- I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
- Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.
- All payments are due at the time of service unless otherwise arranged with the therapist.

Client Signature: _____ Print Name: _____ Date: _____

Guardian Signature: _____ Print Name: _____ Date: _____

(If client is under the age of 18)