

Name _____ Date _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Occupation _____ Age _____

E-Mail _____ (used only for appointments, reminders, newsletters, specials, or massage session follow up.)

How did you hear of me? Embarq Yellow Pages _____ Real Yellow Pages _____ Talking Phone Book _____

Internet Search _____ Website _____ Gift Certificate _____ Road Sign _____ Friend _____

Would you like to receive a newsletter? Yes No If yes, via mail or E-Mail *(please list)*

Have you had massage therapy before? Yes No

For woman: are you pregnant? Yes No If yes, how many months? _____

Do you have allergic reactions to oils, lotions, ointments, liniments, or any other substances put on your skin? Yes No If yes, please explain _____

Please list any particular area of the body where you are experiencing tension, stiffness, or other discomfort. _____

Are you currently under a Doctors care? Yes No If yes, please explain _____

Are you currently taking medications? Yes No If yes, please list _____

List any surgery/ broken bones/ injuries in the past three years _____

Please check any of the following conditions that apply to you:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> A.I.D.S (or related) | <input type="checkbox"/> cancer | <input type="checkbox"/> ears ringing | <input type="checkbox"/> neck pain |
| <input type="checkbox"/> abdominal hernia | <input type="checkbox"/> carpal tunnel | <input type="checkbox"/> edema | <input type="checkbox"/> phlebitis |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> chest pain | <input type="checkbox"/> hand numbness | <input type="checkbox"/> open sore/wounds |
| <input type="checkbox"/> artificial joint/hip | <input type="checkbox"/> cold hands/feet | <input type="checkbox"/> headaches | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> back pain | <input type="checkbox"/> constipation | <input type="checkbox"/> heart condition | <input type="checkbox"/> sciatica |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> contagious conditions | <input type="checkbox"/> herpes | <input type="checkbox"/> sinusitis |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> decreased sensation | <input type="checkbox"/> herniated disk | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> bruise easily | <input type="checkbox"/> diabetes | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> TMJ (temporal |
| <input type="checkbox"/> bursitis | <input type="checkbox"/> diverticulitis | <input type="checkbox"/> low blood pressure | mandibular joint disorder) |

(please sign this form)

I understand that I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problem. It may be beneficial for my massage practitioner to speak to my doctor about my medical condition to determine how massage may help the healing process, and to avoid worsening the condition. I will be asked for permission to contact my doctor, if the massage practitioner thinks that it might be useful. I also understand that it is my responsibility to keep my massage practitioner informed of any changes in my health, and any medications that I may begin to take in the future.

The unclothed body will be properly draped at all time for your warmth, security, and as a mark of massage professionalism.

Focused attention and manual therapy will be given as agreed upon by the therapist and client for the predetermined goals of stress reduction, relief of muscular discomfort, and or health promotion.

I as a client, I agree to provide complete and accurate health information and notice of health changes at successive appointments.

I will immediately inform my therapist of any unusual sensation or discomfort, so that the application of pressure or strikes may be adjusted to my level of comfort.

I understand that the massage is not sexually oriented in any way and that any illicit or suggestive remarks or behavior on my part will result in immediate termination of the session and I agree to pay the full price on time allotted for such session.

I understand that by signing this form, I give consent to receive the treatment discussed in this and all future sessions and agree that my presence at subsequent sessions shall be constructed to be validation of this written consent.

I understand that unless there is an emergency, it is required that I cancel my appointment 24 hours in advance. If I do not call and I do not show for the scheduled appointment, I agree to pay the bill for the entire fee for the missed appointment.

I have read this form and hereby freely give my permission to be massaged.

Signature _____ Date _____